

HEALTH MAINTENANCE ORGANIZATION AMENDMENTS OF 1981

MAY 19, 1981.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. DINGELL, from the Committee on Energy and Commerce,
submitted the following

REPORT

[To accompany H.R. 3398]

[Including cost estimate of the Congressional Budget Office]

The Committee on Energy and Commerce to whom was referred to the bill (H.R. 3398) to amend the Public Health Service Act to revise and extend the program for health maintenance organizations, having considered the same, report favorably thereon with amendments and recommend that the bill as amended do pass.

The amendments (stated in terms of the page and line numbers of the introduced bill) are as follows:

Page 2, line 13, insert, "which provided funds" before "for the fiscal year" and in line 17 insert "which provided funds" before "for such fiscal year".

(3)(A) Section 1310(b)(1) (42 U.S.C. 300e-9(b)(1)) is amended by striking out "provides basic health services" and inserting in lieu thereof "provides more than one-half of its basic health services which are provided by physicians".

(B) Section 1310(b)(2) is amended by striking out "basic health services" and inserting in lieu thereof "its basic health services which are provided by physicians".

Page 3, line 23, strike out "(3)" and insert in lieu thereof "(4)".

Page 6, strike out line 13 and all that follows through line 2 on page 7 and insert in lieu thereof the following:

(h) Section 1302(8) (42 U.S.C. 300e-1(8)) is amended to read as follows:

(8)(A) The term "community rating system" means the systems, described in subparagraphs (B) and (C), of fixing rates of payments for health services. A health maintenance organization may fix its rates of payments under the system described in subparagraph (B) or (C) but not under both systems.

(B) A system of fixing rates of payment for health services may provide that the rates shall be fixed on a per-person or per-family basis and may authorize the rates to vary with the number of persons in a family, but, except as authorized in subparagraph (D), such rates must be equivalent for all individuals and for all families of similar composition.

(C) A system of fixing rates of payment for health services may provide that the rates shall be fixed for individuals and families by groups. Except as authorized in subparagraph (D), such rates must be equivalent for all individuals in the same group and for all families of similar composition in the same group. If a health maintenance organization is to fix rates of payment for individuals and families by groups, it shall—

"(i) classify all of the members of the organization into classes based on factors which the health maintenance organization determines predict the differences in the use of health services by the individuals or families in each class and which have not been disapproved by the Secretary,

"(ii) determine its revenue requirements for providing services to the members of each class established under clause (i), and

"(iii) fix the rates of payment for the individuals and families of a group on the basis of a composite of the organization's revenue requirements determined under clause (ii) for providing services to them as members of the classes established under clause (i)."

The Secretary shall review the factors used by each health maintenance organization to establish classes under clause (i). If the Secretary determines that any such factor may not reasonably be used to predict the use of the health services by individuals and families, the Secretary shall disapprove such factor for such purpose.

(D) The following differentials in rates of payments may be established under the systems described in subparagraphs (B) and (C):

"(i) Nominal differentials in such rates may be established to reflect differences in marketing costs and the different administrative costs of collecting payments from the following categories of members:

"(I) Individual members (including their families).

"(II) Small groups of members (as determined under regulations of the Secretary).

"(III) Large groups of members (as determined under regulations of the Secretary).

"(ii) Nominal differentials in such rates may be established to reflect the compositing of the rates of payment in

a systematic manner to accommodate group purchasing practices of the various employers.

"(iii) Differentials in such rates may be established for members enrolled in a health maintenance organization pursuant to a contract with a governmental authority under section 1079 of 1086 of the title 10, United States Code, or under any other governmental program (other than the health benefits program authorized by chapter 89 of title 5, United States Code) or any health benefits program for employees of States, political subdivision of States, and other public entities."

Page 10, line 14, insert "(a)" after "SEC. 7." and insert after line 25 on page 11 the following:

(b) Section 1310(f)(1) is amended by inserting before the semicolon a comma and the following: "except that such term includes a non-appropriated fund instrumentality described by section 2105(c) of title 5, United States Code".

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I. LEGISLATIVE BACKGROUND

Legislation to amend Title XIII of the Public Health Service Act to revise and extend the health maintenance organization program, H.R. 2480, was introduced on March 11, 1981 by Mr. Waxman and Mr. Gramm. Hearings were conducted on H.R. 2480 and all similar or identical bills on March 18, 1981. The bill as considered in open session by the Subcommittee on Health and the Environment on April 29, 1981, amended, reported, and reintroduced as a clean bill, H.R. 3398 on May 1, 1981 by Mr. Waxman, Mr. Scheuer, Mr. Walgren, Mr. Wyden, Mr. Shelby, Mr. Gramm, Mr. Leland, Mr. Broyhill, Mr. Madigan, Mr. Brown of Ohio, and Mr. Ritter.

H.R. 3398 was considered by the Energy and Commerce Committee on May 12, 1981, amended and ordered reported by a unanimous voice vote.

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II. SUMMARY OF LEGISLATION

The purpose of this legislation is to amend and extend Title XIII of the Public Health Service Act, the Health Maintenance Organization (HMO) program. This title was established by P.L. 93-222, the Health Maintenance Organization Act of 1973."

As approved by the Committee, H.R. 3398 would amend existing law in the manner described below.

(1) The bill authorizes for each of the fiscal years 1982-84 such sums as may be necessary for grants and contracts for the planning and initial development of HMOs for those entities which received funding under grants or contracts in fiscal year 1981. It also authorizes \$1 million for the provision of technical assistance and management training under section 1317.

(2) The bill authorizes for the fiscal years 1982 through 1984, \$40 million, or such greater amount as may be necessary to assure that the HMO loan fund has a balance of at least \$5 million at the end of each fiscal year and to meet the obligations of this fund, including those resulting from defaults on loans.

(3) The bill extends eligibility for loans and loan guarantees for the initial costs of operation of HMOs to private, for-profit HMOs. It increases the aggregate amount of principal of loans made or guaranteed or both for initial costs of operation from \$4.5 million to \$7 million and increases the amount of such loans which may be disbursed in any 12-month period from \$2 million to \$3 million. The bill extends the authority for these loans through fiscal year 1986. It also repeals current restrictions on the amount of loan guarantees which can be made to for-profit HMOs in any fiscal year.

(4) The bill extends eligibility for loans and loan guarantees for ambulatory health care facilities to private, for-profit HMOs. For loans and loan guarantees for ambulatory health care facilities, the bill requires that the HMO provide certification that its revenues exceed its costs of operation. The HMO also would be required to provide assurances that during the period of the loan or loan guarantee its revenues will exceed its costs of operation (including the cost of repaying the loan) and that it was unable to secure a loan from the private market.

(5) The bill allows the Secretary to vary the rate of interest on each disbursement of a loan to an HMO to the rate prevailing for marketable obligations of the U.S. with comparable maturities.

(6) The bill clarifies Title XIII's current requirement that an HMO be a legal entity which, as its primary purpose, provides health services in a specified manner.

(7) The bill repeals the requirement that an HMO have an open enrollment period, the requirement that one-third of the policy-making body of a private HMO be members of the HMO, and the requirement that one-third of the advisory board of a public HMO be members of the HMO.

(8) The bill deletes from the basic health services which a federally qualified HMO must offer (1) short-term (20 visits) outpatient evaluative and crisis intervention mental health services and (2) medical treatment and referral services for the abuse of an addiction to alcohol and drugs. The bill allows an employer offering a federally qualified HMO to require the HMO to offer these serv-

ices, for such payment as the HMO determines to be necessary to cover these services.

(9) The bill deletes the list of supplemental health services which a qualified HMO can offer and specifies that the term "supplemental health services" means any health service which is not included in the definition of basic health services.

(10) The bill revises Title XIII's requirements for community rating to allow a qualified HMO to determine its rates either under the community rating system of current law or under a community rating by class system.

(11) The bill amends the dual choice provisions of Title XIII to require an employer which offers an HMO that is owned or controlled by a commercial insurance carrier or by a nonprofit carrier (such as Blue Cross-Blue Shield), either of which provides coverage to a substantial percentage of the residents of the service area of the HMO, to include also one other qualified HMO which provides services in an area where at least 25 employees reside and in the same manner (i.e., through a staff/group or IPA or individual physicians under contract) as the owned or controlled HMO (if such an additional HMO exists).

(12) The bill repeals the requirement that an HMO cannot enter into contracts with physicians other than members of the staff, medical groups, or IPAs if the amounts paid to other physicians exceed 15 percent (30 percent in rural areas) of the total estimated amount to be paid for physicians' services.

(13) The bill repeals provisions which give priority for assistance to HMOs which serve medically underserved populations and which require a set-aside of appropriations for HMOs serving non-metropolitan areas.

(14) The bill allows an HMO whose service area is located wholly in a nonmetropolitan area to make a basic health service available outside its service area if the service is not a primary or emergency health service and if there is an insufficient number of providers of the service in the area served by the HMO.

(15) The bill amends the requirement that an HMO assume full financial risk on a prospective basis for the provision of basic health services to allow an HMO to make arrangements with physicians or other health professionals, health care institutions, or any combination of these to assume all or part of the financial risk on a prospective basis for the provision of basic health services.

(16) The bill makes minor modifications in the requirements for financial disclosure by qualified HMOs.

(17) The bill amends Title XV of the Public Health Service Act (Health Planning) where it prohibits a State from requiring a certificate-of-need for the institutional health services offered by an HMO, or combination of HMOs, if the HMO or combination has more than 50,000 members. The bill would prohibit a State, effective July 1, 1982, from requiring a certificate-of-need for the institutional health services of an HMO regardless of the number of members of the HMO.

III. COST OF LEGISLATION

As reported by the Committee, H.R. 3398 provides authorization of appropriations in the following amounts.

TABLE OF AUTHORIZATIONS OF APPROPRIATIONS

[In millions of dollars]

	Fiscal year 1982	Fiscal year 1983	Fiscal year 1984
Planning and Initial Development grants.....	(¹)	(¹)	(¹)
Technical assistance and management training	\$1	\$1	\$1
Loan fund.....	(²)	(²)	(²)

¹ Such sums as necessary to phase out fiscal year 1981 grants.² \$40 million or such greater amount as may be necessary.

This can be compared with the recent budget history of Title 13.

BUDGET HISTORY FOR TITLE XIII ¹

	Authorizations	Appropriations
Fiscal year 1979.....	\$31 million.....	\$23.0 million (grants) 1.5 million (tech. assist.)
Fiscal year 1980.....	\$65 million.....	\$43.8 million (grants) 1.5 million (tech. assist.)
Fiscal year 1981.....	\$68 million.....	\$43.0 million (grants) 2.5 million (tech. assist.)

¹ For grants and contracts only; the only appropriation for loans was \$35 million in fiscal year 1975.

IV. BACKGROUND AND NEED

Background

The authority contained in Title XIII of the Public Health Service Act to provide Federal assistance for the development and operation of health maintenance organizations (HMOs) expires in fiscal year 1981. Title XIII also establishes standards for the Federal qualification of HMOs.

As used most generally, the term health maintenance organization describes an entity which provides specific health services to its members for prepaid, fixed payment. In one respect, this arrangement is like a traditional health insurance program in the fee-for-service system. A monthly payment insures some portion of the costs of health services which a subscriber may incur during a period of time.

However, an HMO is different from the fee-for-service system and traditional health insurance programs in a least three respects. First, it is different in its approach to payment to providers of health care services. In an HMO, providers are at risk and are not reimbursed for each of the services they provide, as physicians in the fee-for-service system generally are.

Second, HMOs can be distinguished from a traditional health insurance program in the fee-for-service system by either providing directly or arrange to have provided those services specified in the HMO subscriber contract. A member of a Blue Cross/Blue Shield plan or other private health insurance plan in a fee-for-service arrangement does not have services provided by the plan. Rather, the member secures his own provider or providers whom the plan might then pay.

Finally, a member of an HMO most often is allowed to choose his own physician within the plan. However, the member is not al-

lowed, except under extraordinary circumstances of medical emergency, to seek care from physicians or other providers outside the plan.

These aspects of the HMO concepts are alleged to provide the HMO a capacity and a financial incentive to control the use of health services so as to reduce overall health care costs.

The term health maintenance organization was first advanced in 1970, and was intended to include two basic HMO models: (1) the prepaid group practice model, and (2) the individual practice association or medical care foundation model. In both models, the HMO receives periodic payments of fixed amounts in return for the services it provides to HMO members.

Under the group practice model however, most medical services are provided by physicians who are members of a group practice. Such physicians may be either employees of the HMO (in which case the HMO is often referred to as a staff model) or members of a separate entity which contracts with the HMO to provide medical services to HMO members. Physicians in these arrangements are paid in a variety of ways—the two most common being either by salary, or as a group where the HMO pays the group fixed payments per member each month.

Under the individual practice association or IPA model, physicians in a community contract with the HMO to provide medical services out of their private offices, which can be either solo or group practices. Physicians in IPAs are generally paid on a modified fee-for-service basis with retrospective adjustments based on performance by the HMO and the individual physician. In other words, the fewer expenses incurred by the HMO by the end of the year, the higher the income for physicians.

Group practice HMOs either own their own hospitals, such as is the case for most Kaiser Foundation Health Plans, or arrange for hospitalization for members at one or more community hospitals. The latter arrangement is used in most group practice HMOs, and in almost all individual practice association HMOs.

Because providers are at risk and are not reimbursed for each of the services they provide, HMOs are attractive as a means for cost control because they alter the usual economic incentives in medical care and give providers a stake in holding down costs. Studies have found that the total cost of medical care (i.e., premium plus out-of-pocket costs) for HMO enrollees is lower than it is for comparable people with conventional insurance coverage. The lower costs are clearest for enrollees in HMO group practices, where total costs are from 10 to 40 percent below the costs of conventional insurance enrollees.

Most of these cost differences have been found to be the result of hospitalization rates lower than those of conventionally insured populations. These lower hospitalization rates are due almost entirely to lower admission rates; the average length of stay of a person in a hospital shows little difference in the HMO as opposed to the conventional arrangement.

For example, the last National HMO Census of Prepaid Health Plans indicated, for 1979, the inpatient hospital utilization rate for all HMO plans was 412 days per 1,000 members per year. This compares to an average of about 730 days per 1,000 Blue Cross enrollees nationally in 1978.

In addition, physician visits per member per year for all HMO plans averaged 3.4, and total health plan encounters, including those with the HMOs' nurse practitioners or physicians assistants, per member per year for all plans averaged 4.5 in 1979. The national average was about 5 physician visits per person per year.

The cost-savings potential of HMOs has important implications for public programs as well. For example, one study of Medicaid eligibles enrolled in a Washington, D.C., HMO shows that for the same benefit package, annual per capita costs for 1,000 Medicaid enrollees for 1972, 1973, and 1974 were \$282, \$232, and \$286 respectively, compared with Medicaid fee-for-service per capita costs of \$373, \$435, and \$465 over the same period. Significant and consistent decreases in all four categories of utilization—physician encounters, drug prescriptions, hospital admissions, and hospital days—were found for this group. Overall ambulatory physician encounter rates decreased 15 percent; drug utilization was down 18 percent; hospital admissions decreased 30 percent; and hospital days declined 32 percent after enrollment in the HMO.

An analysis of 1977 data collected in California under the Prepaid Health, Research, Evaluation and Demonstration Project (PHRED) indicates that 13 plans with 104,000 enrollees produced a 16.9 percent savings for the State over costs for fee-for-service beneficiaries. The State of Massachusetts reports comparable savings. In 1977 Medicaid enrollees in the Harvard Community Health Plan produced savings for the State of 19.2 percent compared with eligible persons covered on a fee-for-service basis.

Available evidence also suggests savings for Medicare beneficiaries. Data from seven group practice HMO plans compared with control groups in the same geographic areas—and standardized for age and sex differences—show that in five of these plans, the HMOs saved up to 34 percent over the fee-for-service care provided to the control groups.

In 1979, the Office of HMOs, Department of Health and Human Services (HHS), commissioned a study to determine the estimated rate of return derived from Federal HMO development investments. The study projected cost savings generated by federally assisted HMO projects as compared to the costs of Federal assistance. The study found that Federal assistance costs for HMO development are recovered in the form of community health care cost savings after 8 years of HMO operation, and projected even more substantial future savings. Expressed in 1978 dollars, every dollar invested by the Federal Government will generate an estimated \$1.90 in community cost savings after 10 years of HMO operation; after 15 years of operation, community cost savings are projected to grow to \$7.40 for every dollar of Federal assistance. Adjusted to the value of 1978 dollars the cumulative community cost savings generated by these HMOs would be \$160 million after 10 years of operation and \$635 million after 15 years.

Title XIII of the Public Health Service Act

Title XIII of the Public Health Service Act was established when Congress enacted the Health Maintenance Organization Act of 1973, P.L. 93-222. The authority has been extended and revised twice—once in 1976 (P.L. 94-460) and again in 1978 (P.L. 95-559).

Among other things, Title XIII provides Federal support for the development and operation of HMOs. Grants and contracts are awarded for feasibility surveys and for the planning and initial development of HMOs or for the expansion of existing HMOs. Loan guarantees are also available for planning and initial development. In addition, loans and loan guarantees are available to HMOs for the first 5 years of their operation. Finally, another section in Title XIII provides loans and loan guarantees for the acquisition and construction of ambulatory health care facilities.

Title XIII also establishes standards for Federal qualification of HMOs. In order to be deemed qualified under Title XIII an HMO must provide certain specified basic health services. It must be organized in a certain fashion. The HMO must be fiscally sound, and the payment for enrollment in an HMO must be fixed under a community rating system.

Generally, under a community-rating system, the same premium is charged for the same benefits to all individuals or groups regardless of age, sex composition, and cost experience of the insured. Under experience rating, on the other hand, premiums vary according to the cost experience of each group served. Members of some groups pay higher average premiums than members of other groups under this method. The use of experience rating has in practice tended to make health services most expensive for groups which are at highest risk and/or the highest utilizers of services, such as the aged or chronically ill. Under the community rating system of Title XIII, on the other hand, the HMO must price its services according to the experience in utilization which it has had with its entire enrolled membership.

In addition, Title XIII requires a qualified HMO which has provided comprehensive health services on a prepaid basis for at least 5 years or has an enrollment of at least 50,000 members to have an open enrollment period. During open enrollment, the HMO must accept individuals for membership without regard to preexisting illness, medical condition, or degree of disability.

There is an incentive for HMOs to seek qualified status under Title XIII and to meet these and other requirements. Once an HMO is qualified, it is able to take advantage of what is known as the dual choice requirement.

Under this provision of Title XIII, an employer which is subject to the minimum wage provisions of the Fair Labor Standards Act and which employs at least 25 persons is required to include in its health benefits plan, if it has one, the option of joining a federally qualified HMO serving the area.

Finally, Title XIII authorizes support for technical assistance to developing and qualified HMOs. It also authorizes, as the result of an amendment enacted in 1978, support for a National Health Maintenance Organization Intern Program. The purpose of this program is to provide training for individuals to become administrators and medical directors of HMOs or to assume other managerial positions with these organizations.

As of January 1981, there were 242 prepaid health plans in the country serving over 9 million people. In 1971, there had been 39 prepaid health plans serving 3.5 million persons.

A survey conducted by InterStudy found operating prepaid health plans to be distributed among the States, as follows, for July 1980:

TABLE 1. OPERATING PREPAID HEALTH PLANS BY STATE, JULY 1980

State	Number of plans	Membership July 1980
Alabama.....	1	2,696
Arizona.....	4	161,859
California.....	32	3,992,388
Colorado.....	6	198,478
Connecticut.....	7	74,011
District of Columbia.....	3	185,849
Florida.....	8	147,125
Georgia.....	2	8,912
Hawaii.....	2	147,218
Idaho.....	1	11,381
Illinois.....	12	238,048
Indiana.....	2	27,769
Iowa.....	1	6,200
Kentucky.....	4	33,620
Louisiana.....	3	23,682
Maine.....	2	4,527
Maryland.....	11	96,517
Massachusetts.....	10	173,731
Michigan.....	10	224,529
Minnesota.....	10	409,632
Missouri.....	5	111,233
Nebraska.....	2	16,885
New Hampshire.....	1	11,185
New Jersey.....	9	148,401
New Mexico.....	2	20,001
New York.....	12	971,402
North Carolina.....	1	33,914
North Dakota.....	1	2,803
Ohio.....	12	247,033
Oregon.....	8	334,236
Pennsylvania.....	10	137,317
Rhode Island.....	4	34,918
South Carolina.....	1	5,654
Texas.....	8	93,536
Utah.....	2	27,901
Washington.....	7	390,403
West Virginia.....	3	14,431
Wisconsin.....	16	392,047
Guam.....	1	21,925
Total.....	236	9,183,397

Of the 242 operational prepaid health plans 120 are federally qualified HMOs. These 120 HMOs have a membership of over 6 million persons.

As of the end of fiscal year 1980, grants totaling \$127.5 million had been awarded under the HMO Act.

By the end of fiscal year 1980, 81 HMOs had received direct loans, totaling \$168.6 million and 4 HMOs had received loan guarantees totaling \$7.8 million.

Of the 120 currently qualified HMOs, 63 have received grants and loans, 19 have received grants only, 7 have received loans only, 3 have received loan guarantees, and 28 have received no assistance.

Need

The Committee believes that much of the success of this growth in the numbers of HMOs and their membership can be attributed to enactment of the HMO Act, Public Law 93-222. As a result of this Congressional mandate, HMOs are moving into the mainstream of health-care delivery in the United States and are providing comprehensive and quality medical care to millions of Americans.

Just as significantly, the Federal commitment has also spurred private HMO development that has led to the creation of many prepaid health plans and the expansion of existing plans. These plans are sponsored by commercial health insurers, physician groups, hospitals, major corporations, and labor unions.

According to a survey conducted by InterStudy, there were 226 preoperational prepaid health plans in the country as of February, 1981. Eighty-two of these are federally assisted HMOs and 144 are privately funded. Table 2 indicates the distribution of these preoperational plans by State.

InterStudy has also attempted to determine the source of support for privately funded preoperational prepaid health plans. A preliminary survey of these plans indicates three major sources of funding. These are indicated in table 3.

The Committee has closely followed the development of HMOs for several reasons. First, HMOs, in a documentable fashion, have proved to be an effective counterweight to the rapidly escalating costs of health care in the country, and because of this, the committee believes it important to nurture this promising trend. HMOs have also provided consumers a real alternative for their health care services. HMOs have demonstrated in a variety of settings and in different geographical areas that they are capable of delivering quality medical care for a price that is predictable and significantly less than comparable care provided in the fee-for-service sector.

TABLE 2. KNOWN PREOPERATIONAL PLANS BY STATE AS OF FEBRUARY 1981

State	Total	Federally funded	Privately funded ¹
Alabama	4	2 GP	2 GP.
Alaska	2	1 IPA	1 unknown.
Arizona	8	0	6 IPA; 1 GP; 1 network.
Arkansas	1	1 GP	0
California	23	5 IPA; 1 network	9 IPA; 6 GP; 2 unknown.
Colorado	0	0	0
Connecticut	6	3 IPA; 1 staff	1 IPA; 1 unknown.
Delaware	2	0	2 unknown.
Florida	9	3 staff; 3 unknown	1 IPA; 1 GP; 1 unknown.
Georgia	5	2 IPA	1 IPA; 1 GP; 1 unknown.
Hawaii	2	0	1 GP; 1 unknown.
Idaho	1	0	1 IPA.
Illinois	8	1 IPA; 1 GP; 1 staff	5 IPA
Indiana	6	1 staff	1 IPA; 1 GP; 3 unknown.
Iowa	1	0	1 unknown.
Kansas	4	1 IPA; 3 GP	0
Kentucky	0	0	0
Louisiana	4	0	2 IPA; 1 GP; 1 unknown.
Maine	2	1 IPA	1 network.
Maryland	5	2 IPA	2 IPA; 1 GP.
Massachusetts	15	5 IPA; 2 GP	5 IPA; 1 GP; 2 unknown.
Michigan	10	1 IPA; 1 GP	6 IPA; 1 GP; 1 unknown.

TABLE 2. KNOWN PREOPERATIONAL PLANS BY STATE AS OF FEBRUARY 1981—Continued

State	Total	Federally funded	Privately funded ¹
Minnesota.....	5	1 staff.....	1 IPA; 3 unknown.
Mississippi.....	2	1 IPA; 1 GP.....	0
Missouri.....	7	2 IPA; 1 GP; 1 staff.....	2 IPA; 1 unknown.
Montana.....	0	0.....	0
Nebraska.....	2	0.....	1 GP; 1 unknown.
Nevada.....	1	1 GP.....	0
New Hampshire.....	0	0.....	0
New Jersey.....	9	1 IPA; 1 staff.....	5 IPA; 2 GP
New Mexico.....	0	0.....	0
New York.....	15	3 IPA; 3 staff.....	7 IPA; 1 GP; 1 unknown.
North Carolina.....	6	1 staff.....	1 IPA; 2 GP; 2 unknown.
North Dakota.....	4	2 GP.....	1 IPA; 1 GP.
Ohio.....	5	1 GP.....	1 IPA; 2 GP; 1 unknown.
Oklahoma.....	2	0.....	2 GP.
Oregon.....	2	0.....	1 GP; 1 unknown.
Pennsylvania.....	8	1 IPA; 2 GP; 1 unknown.....	2 IPA; 2 unknown.
Rhode Island.....	1	0.....	1 IPA.
South Carolina.....	1	1 IPA.....	0
South Dakota.....	1	1 unknown.....	0
Tennessee.....	3	2 GP; 1 staff.....	0
Texas.....	14	2 IPA; 3 GP.....	2 IPA; 3 GP; 4 unknown.
Utah.....	7	0.....	2 IPA; 2 GP; 3 unknown.
Vermont.....	2	1 IPA.....	1 unknown.
Virginia.....	3	1 IPA; 1 unknown.....	1 GP.
Washington.....	4	1 IPA.....	2 IPA; 1 GP.
West Virginia.....	2	1 GP; 1 unknown.....	0
Wisconsin.....	2	0.....	1 IPA; 1 unknown.
Wyoming.....	0	0.....	0
Totals.....	226	82 Plans (24 GP; 36 IPA; 1 network; 14 staff; 7 unknown)...	144 plans (68 IPA; 36 GP; 2 network; 38 unknown).

¹ Includes prefeasibility stage.

Group Practice Model (GP)—refers to an HMO that contracts with a group of health professionals for the provision of health services to HMO members. The health professionals work out of a common facility, pool their income from practice as members of the group, distributing it among themselves according to a pre-arranged plan. If the HMO employs its physicians on a salaried basis, it is also referred to as a staff model.

Staff Model HMO—is similar to the prepaid group practice HMO model except that the physicians are employees of the HMO, rather than independent contractors.

Individual Practice Association Model (IPA)—An IPA is an organized group of independent practitioners and/or small groups of physicians gathered together for the purpose of deciding on what basis they shall contract for their services. In an IPA-type HMO, the HMO entity contracts with the IPA organization or directly with individual health professionals who agreed to provide health services to HMO members in accordance with a compensation arrangement. The health professionals work out of their individual offices and are usually reimbursed by the IPA on a fee-for-service basis.

Network Model—The network HMO contracts with more than one medical group and/or IPA organization to deliver care to HMO members in different geographic locations. Each medical group or IPA provides a full range of comprehensive benefits and is contractually linked to a central point of accountability. The benefit package and premiums for each of the medical groups and IPAs in a network are often identical. The prepaid group practice network is characterized by separate and independent delivery points, of which the HMO member selects one to receive all health care services. Most of the network programs in existence were developed by Blue Cross and Blue Shield Plans. The HMO Act does not specifically recognize this model and classifies such programs as IPAs.

TABLE 3.—Estimates of Funding Sources for Privately Developing prepaid health plans, February 1981¹

Sources of funding/sponsor:	
Insurers (5).....	11
Insurer & medical society.....	1
Other national firm (Medserco).....	3
Subtotal.....	15
Blue Cross plans.....	4
Blue Shield plans.....	3
Blue Cross & Blue Shield.....	5
Blue Cross & medical society.....	2
Blue Cross & hospital.....	1
Blue Shield & hospital.....	1
Blue Shield & group practice & hospital.....	1

¹ This list does not include approximately 50 plans which are in the "prefeasibility stage" of development and about 20 plans for whom the funding source is unknown.

Blue Cross & Shield & group practice.....	1
Subtotal.....	18
Medical societies.....	13
Multi-specialty group practice.....	8
Hospitals (1 or more).....	7
Corporations.....	3
Foundations.....	1
Academic medical centers.....	1
University.....	1
County medical center.....	1
Partnership of physicians.....	2
Subtotal.....	² 37
Total.....	70

² Of these plans it may be expected that the bulk of the development capital is coming from the sponsoring agency itself. Most of these 37 firms are health providers who plan to use existing health facilities, staff, and administrators to serve the pre-paid health plans and who thus require less seed money. It is not uncommon, however, for medical societies, hospitals, and group practices to solicit local employers and unions for relatively small amounts of additional funding.

Finally, in enacting the original HMO law, the Federal Government took on a complex new role—that of stimulating the creation of new businesses that were perceived to serve the public interest and monitoring the compliance of these organizations with standards for operation.

V. COMMITTEE PROPOSAL

OVERVIEW

In conducting hearings and in considering legislation to amend the Health Maintenance Organization (HMO) Act, Title 13 of the Public Health Service Act, the Committee has several goals. The Committee wanted to determine the status of HMO development and performance and the most appropriate way to promote continued growth in the number of HMOs and their enrollment; to determine whether any action or inaction by the Federal Government is restraining the competitive impact which HMOs have on the health services and insurance market places; and to evaluate carefully the current regulation of HMOs under Title XIII by the Department of Health and Human Services (HHS) through its Office of Health Maintenance Organizations (OHMO) to determine if any part of that regulatory scheme is unnecessary and warrants repeal.

The Committee found that HMOs, in general, are delivering quality health care, are restraining increases in health care costs in their areas, and are stimulating the development of additional HMOs and other prepaid health care plans in their areas. The number of HMOs and their enrollment is growing significantly, due in large part of the efforts of the Federal grant and loan program conducted by the OHMO; and the amount of private investment and development has increased (see section entitled Background for data).

The Committee determined that the appropriate way to promote additional growth of HMOs is to assure that they can compete. The Committee found that certain action, and in some cases inaction, by the Federal Government contributes to reducing the competitiveness of HMOs and that some regulatory requirements are unnecessary. In response to these findings the Committee's bill would strongly endorse the continuation of dual choice (whereby employees are guaranteed a choice between conventional health insurance and HMOs); would repeal and modify certain regulatory requirements to become a federally qualified HMO (thus eligible to use the dual choice mandate and for loans); would continue to make loans

available at market rates to assure available capital; and would establish certain regulatory requirements to assure that the competitive effect of HMOs is not diminished through direct or indirect control of an HMO by its competitors. With these changes and those contained in a companion bill, H.R. 3399 which modifies reimbursement of HMOs under Medicare and Medicaid, the Committee is confident that the HMO Act will encourage private investment and development and strengthen the ability of federally qualified HMOs to be stable, price competitive, comprehensive prepaid health plans.

The Committee strongly recommends that the Congress support a policy of promoting HMO development. HMOs have tremendous potential for cost containment, while maintaining quality, because they are the *only* health care organizations in the country today which integrate the delivery of health care services with the financing and reimbursement of these services. An HMO contracts with its members to make providers (such as physicians, other health care professionals and hospitals) available to provide services; and it contracts with its providers to provide them. An insurance plan (including Blue Cross and Blue Shield) contracts with its insureds or members to reimburse them or pay their provider if the insured or member finds the provider; and its relationship with providers is an agreement to make payments for services provided. The relationship between the HMO and its providers enables it, through its organizational structure or through financial incentives or risks, to control utilization (particularly inpatient hospital care) and thus costs. While insurance plans can and have taken many steps to reduce utilization, their "fee for service" relationship with providers does not permit them to implement the same kind of utilization controls. The result is that their costs, for the same services, are generally higher.

The Committee recognizes that minimal standards for qualification as an HMO are important. If competition between the fee-for-service system and HMOs is to be aggressive and inure to the benefit of the consumer in the form of lower prices and better access. Then consumers must have the opportunity to opt for enrollment in an HMO. The Congress has required private employers (with 25 or more employees) and state and local governments to offer their employees the choice of membership in a federally qualified HMO. In the 1976 Amendments to the HMO Act, the Congress required the Federal Employees Health Benefits Plan (FEHBP) to offer membership in federally qualified HMOs. In return for offering HMO membership, the Congress sought to assure employers and the FEHBP that HMOs would be fiscally sound and organized so that employers and employees would gain from the efficiencies which accrue from the delivery of comprehensive, at-risk, prepaid health services. This assurance is provided through the requirement for an HMO to become federally qualified.

Because considerable expertise is required to determine if an HMO meets the qualification criteria, employers support the role of the Federal Government. Under these circumstances, the Committee believes that any doubts about the wisdom of a Federal qualification process must be resolved in favor of maintaining it.

EXTENSIONS (SECTION 2)

Grants program

Under current law, the Secretary of Health and Human Services (HHS) is authorized to make grants to and enter into contracts with public and private, non-profit entities for:

- (1) projects for surveys or other activities to determine the feasibility of developing and operating or expanding the operation of HMOs;
- (2) planning projects for the establishment of HMOs or for the significant expansion of the membership of, or areas served by, HMOs; and
- (3) projects for the initial development of HMOs.

For each of these the period and the amount of the grant or contract is different.

The Committee's bill terminates the grant and contract program for these types of projects by phasing it out over the next three fiscal years. During that time, grants and contracts could be made only to entities which received a grant or contract during fiscal year 1980, which grant or contract provided funds for fiscal year 1981, or to entities which received a grant or contract during fiscal year 1981.

Authorizations of appropriations are such sums as may be necessary for each of the fiscal years 1982-1984. While this Committee rarely authorizes appropriations without a specific dollar limitation, the manner in which this grant program operates makes it impossible for the Committee to determine the exact amounts needed. For example, upon completion of the feasibility studies currently being conducted, the Secretary of HHS must determine which projects have demonstrated their feasibility and therefore warrant funds for planning. Experience to date indicates that only a portion of feasibility studies should be continued into the planning stage. Since the number of continuations differ year to year, and since the grant program is being phased out, the Committee provides the Appropriations Committee full latitude.

The Committee recommends that all entities which warrant continuation receive the necessary additional funds during the next three fiscal years. The Federal Government's contribution to the development of HMOs has been significant. HMOs have proven they can deliver quality care at less cost than the fee-for-service sector. With such a performance record, the Committee believes the Congress should support entities still receiving grants and enable them to establish HMOs.

Under current law, the secretary is also authorized to conduct HMO management training programs and to provide technical assistance to developing or operational HMOs. In hearings and throughout the Committee's deliberations the Committee was told repeatedly that the two most serious problems facing HMOs today are the lack of adequate capital and experienced managers. The management training program plays an essential role in encouraging the professional development of HMO managers. The experience with the training program to date is good. The authorizations of appropriations, at one million dollars a year for fiscal years 1982-84, are small but very important to the long range strength of HMOs. As HMOs increase in number the Committee expects the

private sector and educational institutions to assume full responsibility for such training.

The authorizations of one million dollars will also provide technical assistance. The Committee believes this expenditure is appropriate because of the complexity of developing and operating an HMO, which is unlike any other health organization. Integrating providers and hospitals, and the responsibility to deliver health care services, with the financing and reimbursement aspects of insurance make the HMO unique and complex. The availability of technical assistance will be essential for the survival of some HMOs, and generally will strengthen HMOs and the Federal investment in them.

Loan program

As was mentioned in the previous section, the lack of adequate capital is one of the two most important problems for developing HMOs. The Committee was advised that capital is difficult to acquire unless an HMO is affiliated with a commercial insurance company, a Blue Cross or Blue Shield, or the Kaiser Foundation Health Plan in Oakland, California. For other HMOs the combination of the need for up to five years of operating deficit financing, the resulting slow return on investment, and the lack of assets for collateral make them unlikely organizations for substantial private investment. The relative unattractiveness to private investment does not diminish in any way the importance or value of HMOs. It simply indicates that organizing the delivery and financing of a comprehensive, prepaid health services plan is expensive initially, time-consuming, complex, and subject to financial risk.

Under current law the Secretary can make loans and loan guarantees at market rates for the "initial costs of operation" of an HMO during its first five years. The amount of the loan is limited to the projected operating deficit, but may be no more than \$4.5 million. The loans are made from a revolving loan fund, the corpus of which is appropriated. The only appropriations to date were in fiscal year 1975 when \$35 million was put in the fund. The revolving nature of the fund permits the Secretary, through the Office of Health Maintenance Organizations (OHMO), to make loans to HMOs, sell the loan paper to the public through the Federal Financing Bank, return the proceeds from the sale to the fund, and then make new loans. The only time the corpus of the fund is depleted is when the OHMO discounts a loan to sell it (due to interest rates being higher at time of sale than at the time of award to an HMO), or when an HMO declares bankruptcy and the OHMO must pay off the loan (held by the public). Due to discounting and defaults, the \$35 million in the loan fund will be depleted by the end of fiscal year 1981.

The Committee's bill would authorize the loan fund through 1986 (see section 4), and would authorize appropriations to be made to it for three specific purposes during the next three fiscal years (fiscal years 1982-84). The authorization is \$40 million or "such greater amount as may be necessary" to carry out the three purposes, which are:

- (a) to assure that the loan fund has a balance of at least \$5 million at the end of each fiscal year so that new loans can be awarded;

(b) to meet the obligations of the loan fund resulting from defaults on loans made from the fund; and

(c) to meet the other obligations of the loan fund, such as losses due to discounting of loans when selling them.

Predictions as to the number of defaults during the next three fiscal years are understandably difficult to make. The Committee is informed that the highest losses to be expected are \$45 million.

The Committee's bill would authorize the Secretary to continue to make new loans so that new HMOs will have access to the necessary capital to establish themselves. This is purely a banking function, though, because the loans would continue to be made at market rates. (The only subsidy which occurs in the HMO program is with grants, and they are being phased out as described previously.) Because appropriations are necessary only to cover losses to the loan fund (due to discounting and defaults), no appropriations are required to make these new loans. Of course, if there are defaults on the new loans appropriations would be necessary. The Committee notes, though, that relatively few loans will be awarded in the future, because most loan applications have been from entities which received grants.

On balance, the Committee believes the investment in HMOs has returned tremendous dividends in the form of lower health care costs in the areas served by HMOs. Financing the establishment of HMOs involves risk, and has resulted in costs to the Federal Government; but the reduction of health care costs for Medicare, Medicaid, and private citizens already far outweighs those costs or any others that will occur in the future.

REVISION OF REQUIREMENTS FOR HEALTH MAINTENANCE ORGANIZATIONS (SECTIONS 3)

The Committee's bill would repeal or modify a number of the requirements for an HMO to be federally qualified.

Open enrollment

Current law requires an HMO which has operated for five years and has 50,000 members enrolled to have an open enrollment period in any year following a year in which it did not have a financial deficit. The period must be the lesser of 30 days or such time as may be necessary to enroll the number of members equal to three percent of the total net increase in enrollment in the previous year.

The criteria for application of the open enrollment period are so strict that the requirement is rarely applicable. The Committee's bill would repeal it.

Membership of boards of directors

Current law requires the policy making body of a private HMO to be composed of one-third members of the HMO and to have equitable representation from enrolled members who are part of a medically underserved population. For public HMO's an advisory body which meets these requirements is mandated.

The Committee's bill would repeal these requirements. They are unnecessary to assure the HMO's fiscal soundness and operational efficiencies.

Individual practice associations

Current law requires that physicians who provide services to an HMO's enrolled members to be members of the staff of the HMO, a medical group, an individual practice association (IPA), or some combination of these. In addition an HMO can have up to 15 percent of its physician services (measured by amounts paid) provided by physicians who are under contract directly with the HMO.

An IPA is an organization composed of physicians and other health professionals which contracts with the HMO for the provision of health services to the HMO's members. The Committee determined that the requirement for an IPA is unnecessary and that an HMO should be permitted to contract directly with all its health professionals. The bill permits this option by striking the 15-percent requirement, which would allow HMO's to contract with their staffs, medical groups, IPA's or directly with all the physicians who serve their members.

In striking the 15 percent requirement, the Committee does not intend to change any other current requirements regarding the obligations or responsibilities of the physicians in IPA's to HMO's or their members. The bill simply repeals the need to have an IPA as a separate legal entity.

The elimination of the 15 percent requirement affects the classification of HMO's for purposes of dual choice (section 1310(b)(1)). Under current law an HMO is a group or staff type (for purposes of dual choice) as long as no more than 15 percent of its physician services (measured by amounts paid) are provided by physicians under contract with the HMO who are not members of the group (or groups) or staff. With the elimination of the 15 percent rule it is necessary to reestablish a standard for physician services (measured by amounts paid) which must be provided through a group (or groups) or staff. The Committee's bill would require 51 percent or more. This reduced standard is appropriate in order to allow greater flexibility to the HMO in organizing its physician services. This change is not made to require shifting between designations under sections 1301(b)(1) and (2); so the Committee does not expect the OHMO to reclassify as group or staff types those HMO's currently designated as combinations under section 1310(b)(2)(B) because they are providing less than 85 percent of their physician services (measured by amounts paid) through groups or staffs. If an HMO requests redesignation, then such a change would be appropriate.

The Committee's bill, for purposes of dual choice, would classify those HMO's which do not use an IPA but contract directly with all their physicians with HMO's which use IPA's or some combination of groups, staff or IPA's.

Rural HMOs

Current law requires and HMO to provide its basic health services through providers which are in the HMO's service area. The Committee is concerned that this requirement is impossible to meet for some rural HMO's. The bill would permit a rural HMO to offer services which are not emergency or primary health care services outside the service area if providers of those services are not available in sufficient numbers and willing to contract with the HMO on terms consistent with the HMO's mode of operation.

Supplemental services

Current law provides a list of services which an HMO can offer, at its election, and permits the Secretary of HHS to approve other supplemental services. The Committees's bill would permit an HMO complete discretion as to the supplemental services it offers.

Mental health and alcohol and drug treatment services

Current law requires and HMO to provide "basic health services," which are defined in section 1302(1) of the Public Health Service Act. Those services now include "short-term (not to exceed twenty visits, out-patient evaluative and crisis intervention mental health services" and "medical treatment and referral services (including referral services to appropriate ancillary services) for the abuse of and addiction to alcohol and drugs."

The Committee's bill would repeal this requirement for the provision of mental health and drug and alcohol treatment services to the extent that an HMO would be required to provide these services only if an employer requested them. The HMO would have discretion to charge for them on a prepaid or fee for service basis. This discretion is necessary because the HMO might not be providing these services to all members and therefore cannot include them in the rating system for basic health services which are provided to all members.

The Committee's decision to remove the three services from the health services benefit package mandated for all members was based upon the Committee's desire to permit HMO's maximum leeway in developing a benefits package. This change should not be misinterpreted as lack of support for or understanding of the importance of these services. In fact, persuasive evidence was provided by some HMO's that the availability of these services reduced hospitalization rates and thus total costs. Many HMO's now provide, as basic health services, mental health and drug and alcohol services far in excess of those required. The Committee believes that access to these services is crucial for many members of HMO's and encourages HMO's to maintain their current coverage whenever possible. However, where an HMO finds that it is not competitive with other HMO's or health insurance plans, the HMO needs to be able to alter its benefit package to meet demand. The Committee's bill provides this flexibility.

Risk sharing with providers

Current law requires an HMO to "assume full financial risk on a prospective basis for the provision of basic health services". Three exceptions are allowed. They involve insurance coverage or other arrangements for catastrophic costs for only one member, costs for members needing care when outside the service area of the HMO, and financial losses when total costs exceed income by 15 percent.

Regulations have correctly recognized that the structure of an HMO warrants a fourth exception—for sharing risk with physicians and other providers associated with the HMO. The three statutory exceptions all deal with reinsurance and are not intended to preclude the sharing of risk between an HMO and its providers. The Committee's bill would clarify that indeed the fourth exception is permitted. An HMO could share with physicians, other health professionals, hospitals or other health care institutions all or part

of the financial risk on a prospective basis for the provision of basic health services by those individuals or institutions.

Separate legal entities

Current law requires an HMO to be a legal entity, that is, for the HMO itself to be a corporation. Because the current statutory language is subject to misinterpretation, the Committee's bill would amend it to state specifically that the "primary purpose" of an HMO must be to provide services to its members according to the HMO Act and be organized and operated according to the HMO Act. Because an HMO might do some other things as a consequence of its activities as an HMO, the Committee used the term "primary." The goal of the Committee is to assure that the other purpose of purposes do not conflict with the corporation's activities as an HMO.

The conflict which is of greatest concern to the Committee, and which compels the continuation of this requirement, would arise if a commercial health insurance company or a Blue Cross or Blue Shield plan could also be an HMO. HMO's are the natural competitors of these insurers; so the requirements of the HMO Act should assure that HMO's can aggressively compete with them. The HMO Act requires an employer to offer only one group practice or staff type HMO and only one IPA type HMO. If the only HMO (of one type) which has guaranteed access to employers could be operated by an insurance company, as a division of its health insurance business, the opportunities for the HMO to compete against the insurance line of business would be seriously, perhaps fatally, compromised. Other competitive HMO's would be precluded from developing and the possibility of a competitive health services market would be lessened. Under such a circumstance, the HMO would be used by the insurance company to expand its total market share instead of to create a more competitive market. As long as employers are required to offer only one HMO (of one type), the requirement for an HMO to be a separate legal entity will provide some minimal assurance that the one HMO will operate in its best interest and be competitive.

The Committee also recognizes that if an HMO could be a division of any other business there could be substantial difficulty in determining whether the HMO is fiscally sound and operating in accordance with Title XIII. These problems are avoided by requiring the HMO to be a separate corporation.

There are some costs associated with the establishment of a corporation; but it is the Committee's understanding that they are minimal. Many insurance companies have already started HMO's as separate legal corporations; and based on that experience the Committee concluded that the requirement can be satisfied.

Community rating

Under current law an HMO is required to use a "community rating system." Under this system premium rates are the same for all individuals in the HMO and all families of similar composition in the HMO. (Certain limited differentials are permitted.)

Much of the testimony received by the Committee concerning the community rating system criticized it for not permitting an HMO adequate flexibility to set different premium rates for the different

groups to which it markets. Even though HMO's generally provide services for less total cost, their rates are often higher than competing insurance plans because HMOs generally offer a broader range of benefits. The view of those critical of community rating was that HMO's could compete more effectively if they had greater rate-setting freedom.

It is the Committee's understanding that HMO's have not taken advantage of the flexibility available to them under the current community rating system. In order to allow a lower premium rate to be charged, current law permits an HMO to charge copayments (additional payments at the time a service is received) for the provision of any basic or supplemental health service. By offering to existing and prospective HMO members the option of a low, or high, copayment plan, premium rates could be reduced substantially and those HMO's could better compete on the basis of price with insurance plans whose premium rates are lower.

In spite of the lack of use of this copayment option, the Committee determined that flexibility in the fundamental rate-setting system should be permitted. The Committee's bill would retain the copayment option and modify community rating. The Committee believes that with this additional flexibility HMO's will be able to compete effectively on the basis of price.

The Committee's bill would amend the "community rating system" so that an HMO, while still using a form of community rating, could set different premium rates for different groups. This new system can be called "community rating by class" and would work in the following manner.

First, it is necessary to explain the terms "group" and "class." The main market for HMO's is groups of individuals. A group is usually the employees of one employer; but it also could be composed of the employees of a number of small employers or the members of an association or club. As used in the bill, the term "group" refers to these types of employee groups or other aggregations of individuals who wish to purchase HMO membership under contract. Current regulations describe a "group" in this manner. A group could not be established based on characteristics such as sex or race.

Under this new community rating by class system, an HMO would establish "classes" of individuals and families. A class could not be a "group" (such as one employer's employees), or a combination of two or more groups (such as steel workers), or be based upon any proxy for a group or groups (such as occupation). A class would be actuarially derived or based on other factors which predict differences in the use of HMO services by individuals or families with the characteristics of the class. For example, individuals between the ages of 18 and 40 could be one class if people of that age are expected to have similar health care utilization patterns and people younger and older are expected to use services differently. The purposes of these classes is to put all individuals and all families who are expected to have similar utilization experiences (and thus similar costs to the HMO) into the same class, regardless of which groups they are from. The number of classes and the factors used to establish classes are left to the discretion of the HMO; except that the Secretary would review the factors when an HMO applies for federal qualification (or when an existing HMO applies

for authority to change to this new rating system) and could prohibit the use of any factor which he determined could not reasonably be used by an HMO to predict the use of its health services by its members.

An HMO currently operating would take all enrolled individuals and families (individuals of a group who have coverage for their family) from all groups to which it markets and distribute them into the classes the HMO has established. It also would distribute any new enrollees from a group to which it currently markets, or a new group to which it is marketing for the first time, into these same classes. An HMO which is developing would distribute members into these classes as they enroll.

The HMO would then establish the amount of revenue required from each class to provide covered services to that class based upon that class' projected utilization.

The HMO would then establish, for each group, a composite premium rate for all individuals in the group and for all families of similar composition in the group. (Composition refers only to size.) The rate would be the same for all individuals in the group and for all families of similar composition in the group. The composite rate for the individuals in one group would be derived by (1) multiplying the revenue requirements for each class by the number of individuals from the group in that class; (2) adding the revenue requirements for all classes of individuals from the group; and (3) dividing the total revenue requirements for all individuals by the total number of individuals in the group. The process is similar for families; except that if classes are established based only on the number of persons in a family, the premium rate for families of the same size would be equivalent to the revenue requirements for that class.

The following chart shows how the composite rate is established for two hypothetical employers.

COMMUNITY RATING BY CLASS

Class No. 1—individuals under 30

Class No. 2—individuals between 30-55

Class No. 3—individuals between 55-65

Class No. 4—families of 2

Class No. 5—families of 3 or more

Group No. 1—Franklin Clothing

Group No. 2—City of Jacksboro

	Group No. 1: number of persons	Revenue requirements per person	Group No. 2: number of persons
Class No. 1.....	50	\$10 month.....	10
Class No. 2.....	20	\$20 month.....	20
Class No. 3.....	10	\$30 month.....	50
Class No. 4.....	40	\$20 month.....	10
Class No. 5.....	40	\$40 month.....	70

PREMIUM RATES

	Group No. 1	Group No. 2	Community rate (under current law)
Class No. 1	\$500	\$100.....	
Class No. 2	\$400	\$400.....	
Class No. 3	\$300	\$1,500.....	
Total	\$1,200	\$2,000.....	\$3,200
Number of individuals	80	80.....	160
Composite rate for individuals.....	\$15	\$25.....	\$20

Note.—These classes of families vary only by family size; so the premium rates for classes No. 4 and No. 5 are the same as the revenue requirements.

Section 3(h) of the bill, before amended by the Committee, raised questions as to whether individuals in the same group could be charged different premium rates because they were in different classes or because of differences in their sex or marital status. Since the Committee did not intend such results, the Committee amended that section to make very clear that individuals in the same group must pay the same premium rate regardless of whether they are in the same class, and regardless of their sex or marital status; and that families of similar composition in the same group must pay the same premium rate regardless of whether they are in the same class. It is the Committee's intention that premium rates may not differ for individuals in the same group because of individual's sex or marital status.

This new rating system will permit an HMO to establish different premium rates for different groups, and thereby to reflect the different risks faced by it in providing health services to the enrolled members of each group. If one group of employees is composed of relatively young individuals with few families, the premium rates will be lower than for a group of employees is composed of relatively older individuals with many large families. This new system does not permit experience rating, which involves the establishment of premium rates for a group based solely on the utilization experience of that group in the previous contract year. This system will provide substantial new flexibility in rate-setting and will allow HMO's to set more competitive rates.

LOANS AND LOAN GUARANTEES FOR INITIAL OPERATIONS AND AMBULATORY FACILITIES (SECTIONS 4, 5 AND 6)

Under current law an HMO may receive a loan at market rates or a loan guarantee for a market rate loan for two purposes. First, a loan or guarantee may be awarded to a public or private non-profit HMO to cover the amount by which its costs of operation exceed its revenues during the first sixty months of operation, or during the first sixty months of operation after a significant expansion of membership or area served. The total amount of the loan or guarantee is \$4.5 million and no more than \$2 million can be distributed annually. A for-profit HMO may only receive a loan guarantee, under these conditions, and only if it serves a medically underserved population.

The Committee's bill would make some modification in these loans and guarantees and extend the authority to make them until

1986. Because of inflation and the need for greater amounts of capital to start an HMO, the ceilings on the amount of loans or guarantees would be raised to \$7 million, in total, and \$3 million annually. The Committee heard convincing evidence that current loan limits are inadequate. For example, a recently organized group practice HMO in Dallas, Texas, jointly established by the Kaiser Foundation Health Plan and Prudential Insurance Company of America will require \$6 million of operational deficit financing (in addition to in-kind staff support from both sponsors) to reach break even and \$10-\$15 million for facilities construction during the first 10 years of operation.

The Committee's bill also would permit a for-profit HMO to receive loans or guarantees, under the same conditions, regardless of the area it serves. Since all grants are being phased out; these loans and guarantees are at market rates; and capital to begin HMO's is difficult to obtain for any organization; the Committee determined that for-profit HMO's should also have access to Federal loans. This policy is consistent with the Committee's goal of promoting the development of new HMO's without subsidizing their development.

The second purpose under current law for which market rate loans or guarantees may be made is for ambulatory facilities for HMO's. Public and private non-profit HMO's may receive up to \$2.5 million for the acquisition or construction of an ambulatory care facility and for the acquisition of equipment for the facility. For-profit HMO's may receive guarantees only, and only for serving medically underserved areas.

The Committee's bill would modify the eligibility criteria for these loans and guarantees in order to assure that they are made only to HMO's which are fiscally sound. The applying HMO would have to include certification from an independent auditor that its revenues exceeded its costs at the time of application, and assurances satisfactory to the Secretary that market rate loans are unavailable from private sources and that the HMO will remain profitable throughout the period of the loan or guarantee. If an HMO has surplus revenues at the time of application, and is well organized and administered so that it can be expected to continue with an operating surplus; and if its projected enrollment growth and costs during the period of the loan are expected to result in an operating surplus for the period of the loan; then the HMO should be capable of repaying any Federal loan or guarantee. In requiring an operating surplus throughout the period of the loan, the Committee expects that some fluctuations could occur, even resulting in a temporary deficit position. The purpose of these requirements is to gauge the long run financial strength of the applying HMO.

An HMO in such circumstances would appear to be safe for private loans. However, because ambulatory medical facilities are single-purpose buildings they are not particularly good collateral; and because HMO's, even with a surplus, can still have relatively few assets, private lenders have been reluctant to make the necessary capital available. Under these circumstances the Committee believes that the relatively small risk of HMO failure and loss of the Federal loan or guarantee is outweighed by the benefits which will accrue from the growth of HMO enrollment. These benefits of

lower health care costs do not accrue to private lenders; so it is understandable that they balance their interests differently.

The Committee's bill also makes for-profit HMO's eligible for these loans and guarantees, for the same reasons as with the operational loans. It also repeals the authority of the Secretary to guarantee loans originated by the Federal Financing Bank (FFB) for ambulatory facilities. This change does not affect the role of the FFB in selling loan paper originated by the Secretary through the Office of Health Maintenance Organizations.

The last change the Committee's bill would make, regarding these loans, would permit the Secretary to vary the rate of interest on the loan with each disbursement of the loan. Under current law the Secretary (through the OHMO) sets an interest rate in awarding the loan. Under this amendment, the Secretary would set a rate on the portion disbursed initially and could vary the rate on each portion of the loan disbursed subsequently. This procedure would eliminate losses to the loan fund due to discounting loans when sold because of higher interest rates at the time of sale than at the time the loan was awarded.

HEALTH BENEFITS PLANS (SECTION 7)

Dual choice

Under current law an employer with 25 or more employees must offer one group practice or staff-type HMO and one IPA-type HMO. The Committee received testimony that this dual choice mandate, under which an employee can choose between the HMO's and a health insurance plan, is still important for HMO's to gain access to employee groups.

Employers usually decide (through negotiation if a labor union is present) on the benefits to be provided to their employees and then receive bids from commercial health insurance companies and Blue Cross and Blue Shield plans to provide insurance coverage for those benefits. Increasingly employers are also self insuring. The result is that employees don't "choose" the health insurance company to cover their benefits. Dual choice permits employees a choice, and in so doing, creates a new form of competition for health care services which has the potential for restraining health care costs. In the face of competition from HMO's, health insurance companies attempt to restrain unnecessary utilization and otherwise reduce the costs of their health insurance coverage.

As explained earlier in the discussion of "Separate Legal Entities" (in section 3 of the bill), the Committee is concerned that the competitive effect of dual choice could be lessened, or eliminated, if a commercial health insurance company or a Blue Cross or Blue Shield plan managed the only HMO (which was offered as a choice) as a division of its health insurance business. Even if an HMO is a separate legal entity, ownership or control by such a company or plan of the only HMO offered as a choice could also have an anti-competitive effect. The Committee's bill would provide additional assurance against this occurrence with the following requirement.

If a commercial health insurance company or a Blue Cross or Blue Shield plan has a substantial share of the private health insurance market in an area served by an HMO; and if that HMO is owned or controlled by such company or plan; and if an employer

offers that HMO to satisfy its obligations under dual choice; then that employer would have to offer one other HMO (if it exists) of the same type which is not owned or controlled by such company or plan. Whether or not a company or plan has a substantial market share would depend upon the particular circumstances of a community and should be decided on a case basis. If one company or plan has 40 percent to 50 percent of the market, they would probably have a "substantial" share; but if there were two or more companies or plans with 20 percent or more of the market, no one company or plan would probably have a "substantial" share. The Committee recognizes the difficulties of such a determination and believes that with proper implementation and consultation it can be accomplished.

The Federal Trade Commission has considerable expertise in evaluating market concentration and should be consulted before the Secretary undertakes any determinations under this provision. The implementation must provide for a definitive determination with maximum certainty as soon as possible for all interested parties. This can be done by requiring the HMO, entering into the market with the owned or controlled HMO, to request that a determination be made as part of its Federal qualification and before it begins operations. This would allow the existing HMO and parent insurance company or plan to participate in the determination and would put all interested parties (particularly the employers) on notice of a final decision before the additional HMO begins marketing. If the incoming HMO is in an area where employers are willing to offer multiple HMO's, then the substantial market test would never have to be applied. If the owned or controlled HMO is the incoming plan, and employers offer it instead of the original HMO, then a determination should be made within a limited period, established by the Secretary, after the original HMO first requests a determination of the substantial market share test. The Committee does not intend for the Secretary to require an HMO, which is owned or controlled, to establish the market share of its parent unless a request is made by a competing HMO.

Nonappropriated fund instrumentalities

The Committee's bill would extend to the employees of nonappropriated fund instrumentalities the dual choice option which currently applies to employees of private employers and state and local governments.

In the 1976 amendments to the HMO Act, Federal employees, including those of nonappropriated fund instrumentalities (NAFI's), were removed from the requirement of dual choice because the Federal Employees Health Benefits Plan (FEHBP) was amended to require the offering of all federally qualified HMO's. Employees of NAFI's were not, in 1976, and are not now considered to be federal employees for purposes of the FEHBP. The Committee's amendment would address this inconsistency.

REPEAL OF SPECIAL CONSIDERATIONS (SECTION 8)

Current law requires the Secretary to give special consideration to applications for grants from entities which want to establish HMO's to serve medically underserved areas. Current law also re-

quires that 20 percent of appropriations for grants be awarded to entities which want to establish an HMO to serve rural areas.

Because the grant program is being phased out, the Committee's bill would eliminate these provisions.

FINANCIAL DISCLOSURE (SECTION 9)

Current law requires that certain financial information be disclosed to the Secretary in the form of reports. If the Secretary determines that these reports disclose prohibited behavior, federal qualification can be rescinded if the behavior affects the HMO's fiscal soundness (as required under section 1301(c)).

The Committee's bill would modify some of these requirements. Instead of requiring all HMO's to submit the information mandated by sections 1124 and 1902(a)(38) of the Social Security Act, those HMO's which participate in the Medicare and Medicaid programs, and thus are required to submit reports under those sections, would submit a copy of those reports. The bill clarifies that salaries paid to employees in the normal course of employment are not reportable transactions; and that only "managing" employees and the spouse, children and parents of other parties in interest are parties in interest. The Committee believes that only those employees who manage HMOs and thus make decisions for an HMO affecting its assets or business transactions should be considered a party in interest.

In general the Committee believes the Secretary should review all financial disclosure reporting and continue only that which is necessary to assure that federally qualified HMO's are fiscally sound.

MISCELLANEOUS (SECTION 10)

The Committee's bill would repeal section 1314 which required GAO to make certain reports to the Congress. All reports have been submitted.

The Committee's bill also would amend the section of the current health planning law (section 1527(b) of the Public Health Service Act) which prohibits a State from requiring a certificate of need for the institutional health services offered by a HMO. That section prohibits State coverage if an HMO, or a combination of two or more HMO's, has more than 50,000 members. The bill would prohibit State coverage regardless of the number of members. The amendment would take effect on July 1, 1981.

SOLVENCY OF FEDERALLY QUALIFIED HMO'S

The HMO Act currently provides that each HMO shall "have a fiscally sound operation and adequate protection against the risk of insolvency which is satisfactory to the Secretary." There are currently 120 federally qualified health maintenance organizations and to date 10 federally qualified plans have ceased operations. Of those plans no longer doing business, HMO members have been fully protected from the claims of providers in all but one instance, the failure of an IPA in Fort Collins, Colorado. The Committee shares the concerns expressed by employers during the hearings that all HMO members should be protected from provider claims in

the event of HMO insolvency. The Committee believes that the language of present law provides adequate authority for the Secretary to require such measures as are necessary to protect members and their employers against the failure of their HMO. The need for review of this matter is urgent, however, so the Committee strongly recommends that the Secretary undertake an immediate review to determine the appropriate measures which should be implemented. Options available to the Secretary include the creation of appropriate reserves to assure satisfaction of provider claims, the use of loan funds to fund such reserves, hold harmless clauses in contracts between HMO's and providers and guarantees by parent companies to cover all outstanding debts at time of insolvency. In implementing this authority the Secretary should consider such factors as the fiscal health of the HMO over the past year, adherence to sound accrual accounting principles, the overall strength of HMO management, the potential impact upon the HMO of state reserve and other requirements, other factors relevant to the HMO's prospects for long-term stability, and the need to phase in any new requirements. The Committee notes that the National Association of Insurance Commissioners is near completion of its model state law provision on HMO solvency and anticipates that the action of the NAIC will produce an effective state response to the problem of member protection in the event of HMO failure.

If additional bankruptcies occur, the Committee intends for the Secretary to continue the current practice of the OHMO of seeking other HMO's or entities to take over the failed HMO. The Committee strongly recommends that the Secretary review current procedures for identifying HMO's in financial trouble as early as possible, for requiring immediate compliance action, for advising employers as soon as appropriate, and for requiring financially troubled plans, as a condition of Federal loan support, to enter discussions for new ownership or receivership if necessary.

Compliance

The grant, or development, function of the OHMO is just one part of its mission. So even though the grant program would be phased out by the Committee's bill, it is very important that the qualification and compliance activities of the OHMO be maintained and strengthened.

Because many HMO's are expected to seek federal qualification in the future, and because a federally qualified plan can require its offering to employees, it is critical that the qualification capabilities of OHMO remain intact. Because millions of dollars of federal loans are currently outstanding and because new loans can continue to be awarded, it also is critical that the compliance capabilities of OHMO remain intact.

The Committee believes that the Congress, once again, should place its imprimatur on the future development of HMO's. Individuals who enroll and employers who offer HMO membership deserve for only fiscally sound and well organized HMO's to receive and retain federal qualification.

VI. PROGRAM OVERSIGHT

The Committee's principal oversight activities with respect to this program have been conducted by the Subcommittee on Health and the Environment in connection with its consideration of the legislative authorities for this program. Legislative hearings were held on March 18, 1981. The findings of the Committee's oversight activities are discussed in this report under "committee proposal," as the proposed legislation is designed to respond to the Subcommittee findings.

The Committee has not received reports from either its own Subcommittee on Oversight and Investigations or the Committee on Government Operations.

VII. INFLATION IMPACT STATEMENT

The Committee anticipates that the enactment of H.R. 3398 will have a beneficial impact on inflation by reducing the rate of increase in medical care costs. Recent studies indicate that HMO's are generating substantial savings to their members. Because HMO's have a financial incentive to keep their members well, and because HMO's have been successful in reducing the rate of hospitalization for their members, HMO's have generated cost savings of 10 to 40 percent.

The Committee also expects that HMO's will compete with the fee for service system and with other forms of health insurance on the basis of price. Such competition will play an important role in restraining the rate of increase in the costs of all health providers and in the premiums charged by other forms of health insurance. By fostering this competition this legislation will have a beneficial impact on the rate of inflation in medical care costs.

VIII. CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

A cost estimate was requested on H.R. 3398 when it was ordered reported from the Committee on Energy and Commerce, and the Congressional Budget Office has provided the following information:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, D.C., May 15, 1981.

Hon. JOHN D. DINGELL,
Chairman, Committee on Energy and Commerce, U.S. House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: Pursuant to Section 403 of the Congressional Budget Act of 1974, the Congressional Budget Office has prepared the attached cost estimate for H.R. 3398, a bill to amend the Public Health Service Act to revise and extend the program for health maintenance organizations.

Should the Committee so desire, we would be pleased to provide further details on the attached cost estimate.

Sincerely,

ALICE M. RIVLIN, *Director.*

CONGRESSIONAL BUDGET OFFICE, COST ESTIMATE, MAY 15, 1981

1. Bill number: H.R. 3398

2. Bill title: A bill to amend the Public Health Service Act to revise and extend the program for health maintenance organizations.

3. Bill status: As ordered reported by the House Committee on Energy and Commerce on May 12, 1981.

4. Bill purpose: The bill would extend for three years the authorization for grants and contracts for planning and initial development costs of health maintenance organizations (HMO's). The bill would also extend for three years the authorization for grants and contracts for training and technical assistance relating to health maintenance organizations. Finally, the bill would authorize for the next three years appropriations to assure that the HMO loan fund has a balance of at least \$5,000,000 at the end of each fiscal year and to meet obligations resulting from defaults on loans made from the fund and to meet other obligations of the fund.

5. Cost estimate:

[By fiscal years, in millions of dollars]

	1982	1983	1984	1985	1986
Authorization levels:					
Planning and initial development costs (1304(a) and 1304(b)).....	38	3			
Training and technical assistance (1317).....	1	1	1		
General provisions relating to loan guarantees and loans (1308(e)).....	40				
Total authorization levels.....	79	4	1		
Estimated outlays:					
Planning and initial development costs (1304(a) and 1304(b)).....	20	11	8	2	
Training and technical assistance (1317).....	0.5	0.7	0.9	0.5	0.4
General Provisions relating to loan guarantees and loans (1308(e)).....	21	9	7	3	
Total estimated outlays.....	41.5	20.7	15.9	5.5	0.4

The costs of this bill fall within function 550.

6. Basis for estimate: Most authorization levels are stated in the bill. Unspecified amounts have been estimated by CBO.

The bill would authorize for 1982, 1983, and 1984 such sums as may be necessary for continuing planning and initial development grants for HMOs that have received such grants prior to fiscal year 1982. On the basis of information provided by the Department of Health and Human Services, it is assumed that 46 grants and contracts will be awarded in 1982 at an average cost of \$0.8 million and that grants and contracts will be awarded in 1983 at an average cost of \$1 million.

Authorized amounts are assumed to be fully appropriated at the beginning of each fiscal year. Outlays are estimated using spendout rates computed by CBO on the basis of appropriate recent program data.

7. Estimate comparison: None.

8. Previous CBO estimate: None.

9. Estimate prepared by: Hinda Ripps (225-7766)

10. Estimate approved by: James L. Blum, Assistant Director, for Budget Analysis.

IX. AGENCY REPORTS

Agency reports were requested on H.R. 2480, a similar predecessor to H.R. 3398, on March 15, 1981 from the Office of Management and Budget and the Department of Health and Human Services.

No reports had been received when this report was filed.

X. SECTION-BY-SECTION ANALYSIS

The purpose of this bill is to amend the Public Health Service Act to revise and extend the health maintenance organizations program.

Section 1. Short title, reference to act.

Section 2(a): During the next three fiscal years (fiscal years 1982-84), grants for planning an HMO and for the initial development of an HMO may only be made to entities which received a feasibility, planning or initial development grant during fiscal year 1981, the current fiscal year. Appropriations are authorized in such sums as are necessary to award these grants. Also, appropriations of \$1 million a year for the next three fiscal years (fiscal years 1982-84) are authorized to provide technical assistance and management training under section 1317 to HMO's.

Section 2(b): During the next three fiscal years (fiscal years 1982-84) appropriations are authorized for the loan fund so that new loans can be made and the obligations of the loan fund can be met. Authorizations are \$40 million or such greater amount as may be necessary to accomplish the purposes of the loan fund.

Section 2(c): Permits loan guarantees for planning and initial development (in lieu of grants or contracts) to continue to be made during the same period in which grants and contracts for such purposes can be awarded.

Section 3(a): Clarified the current requirement of section 1301(a) that an HMO must be a separate legal entity.

Section 3(b): Repeals the current requirement that an IPA-type HMO (Individual Practice Association) create the IPA as a legal entity. The HMO could, under this amendment, contract directly with physicians instead of contracting with the IPA as a representative of all the physicians.

Section 3(c): Permits a rural HMO to contract with providers who are not in the HMO's service area for the provision of specialty and secondary health care services to the members.

Section 3(d): Repeals the current requirements that an HMO have an open enrollment period as described in section 1301(d); that one-third of the policy making body of a private HMO be members of the organization; and that a public HMO have an advisory board composed of one-third members of the HMO.

Section 3(e): Clarifies the interpretation of current law by the Department of Health and Human Services regarding the authority of an HMO to share the risk of providing health services with physicians, other health professionals and hospitals.

Section 3(f): Removes outpatient mental health and drug and alcohol treatment services from the mandatory benefit package

which a federally qualified HMO must provide to all members. Such an HMO would be required to provide these services to an employer which requested them.

Section 3(g): Repeals the list of services included in the definition of "supplemental health services" and the requirement that the Secretary of Health and Human Services approve any other services as supplemental health services. Permits the HMO to offer whatever supplemental health services it chooses to provide.

Section 3(h): Changes the current community rating system to permit an HMO to use a rating system based on actuarial classes.

Section 4(a-c): Permits loans and loan guarantees for the initial costs of operations of an HMO to be made to any for-profit HMO (in addition to current authority to make loans to non-profit HMO's). Raises the ceiling on the total amount of loans which can be made to an HMO from \$4.5 million to \$7 million; and raises the ceiling on the annual distribution of an approved loan from \$2 million to \$3 million. Extends the loan fund through 1986.

Section 4(d): Repeals the current restriction on the amount of loan guarantees which can be made to for-profit HMO's in any fiscal year.

Section 5: Modifies the current authority to make loans for the construction and acquisition of ambulatory care facilities of HMO's. Requires an HMO to have revenues which exceed its costs and to be unable to secure the loan elsewhere.

Section 6: Permits the Secretary of HHS to vary the rate of interest in each disbursement of a loan made to an HMO.

Section 7: Expands the current requirements for those employers who are required by 1310(a) to offer qualified HMO's. If such an employer includes in its health benefits plan an HMO which is owned or controlled by a commercial insurance company or a Blue Cross or Blue Shield plan, which company or plan has a substantial share of the private health insurance in the area, the employer would also have to include one other HMO which provides services in the manner (for example, through a group of an IPA) as the owned or controlled HMO if such an additional HMO exists.

Section 8: Repeals the current special consideration given to applications for grants and contracts for feasibility studies, planning and initial development of HMO's in rural areas and those serving medically underserved populations. Also repeals the current set-aside of appropriations for funding grants and contracts for HMO's serving rural areas.

Section 9: Modifies some of the financial disclosure reporting requirements to make them less burdensome.

Section 10(a): Repeals the section which required GAO to make certain reports to Congress. All reports have been submitted.

Section 10(b): Amends the section of the current health planning law which prohibits a State from requiring a certificate of need for the institutional health services offered by a HMO. The current section, 1527(b), prohibits State coverage if an HMO, or a combination of two or more HMO's, has more than 50,000 members. Section 10(b) would prohibit State coverage regardless of the number of members. This amendment would take effect on July 1, 1982.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3 of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in *italic*, existing law in which no change is proposed is shown in roman):

PUBLIC HEALTH SERVICE ACT

* * * * *

TITLE XIII—HEALTH MAINTENANCE ORGANIZATIONS

REQUIREMENTS FOR HEALTH MAINTENANCE ORGANIZATIONS

SEC. 1301. (a) For purposes of this title, the term "health maintenance organization" means a legal entity which (1) *as its primary purpose* provides basic and supplemental health services to its members in the manner prescribed by subsection (b), and (2) is organized and operated in the manner prescribed by subsection (c).

(b) A health maintenance organization shall provide, without limitations as to time or cost other than those prescribed by or under this title, basic and supplemental health services to its members in the following manner:

(1) * * *

* * * * *

(3)(A) Except as provided in subparagraph (B), the services of a physician which are provided as basic health services shall be provided through—

(i) members of the staff of the health maintenance organization,

(ii) a medical group (or groups),

(iii) an individual practice association (or associations),

(iv) [subject to subparagraph (C),] physicians or other health professionals who have contracted with the health maintenance organization for the provision of such services, or

(v) any combination of such staff, medical group (or groups), individual practice association (or associations) or physicians or other health professionals under contract with the organization.

[(C) After the expiration of the first four fiscal years of a health maintenance organization beginning after the month in which it became a qualified health maintenance organization (within the meaning of section 1310(d)), the organization may not enter into contracts with physicians other than members of staff, medical groups, or individual practice associations if the amounts paid under such contracts for basic and supplemental health services provided by physicians exceed 15 per centum of the total estimated amount to be paid in such fiscal year by the health maintenance organization to physicians for the provision of basic and supplemental health services by physicians, or, if the health maintenance organization principally serves a rural area, 30 per centum of such amount, except that this sub-

paragraph does not apply to the entering into contracts for the purchase of physician services through an entity which, but for the requirements of section 1302(4)(C)(i), would be a medical group for the purposes of this title.]

[(D)](C) Contracts between a health maintenance organization and health professionals for the provision of basic and supplemental health services shall include such provisions as the Secretary may require (including provisions requiring appropriate continuing education).

[(E)](D) For purposes of this paragraph the term "health professional" means physicians, dentists, nurses, podiatrists, optometrists, and such other individuals engaged in the delivery of health services as the Secretary may by regulation designate.

(4) Basic health services (and only such supplemental health services as members have contracted for) shall within the area served by the health maintenance organization be available and accessible to each of its members promptly as appropriate and in a manner which assures continuity, and when medically necessary be available and accessible twenty-four hours a day and seven days a week, *except that a health maintenance organization which has a service area located wholly in a non-metropolitan area may make a basic health service available outside its service area if that basic health service is not a primary care or emergency health care service and if there is an insufficient number of providers of that basic health service within the service area who will provide such service to members of the health maintenance organization.* A member of a health maintenance organization shall be reimbursed by the organization for his expenses in securing basic and supplemental health services other than through the organization if the services were medically necessary and immediately required because of an unforeseen illness, injury, or condition.

* * * * *

(c) Each health maintenance organization shall—

(1)(A) have a fiscally sound operation and adequate provision against the risk of insolvency which is satisfactory to the Secretary, and (B) have administrative and managerial arrangements satisfactory to the Secretary;

(2) assume full financial risk on a prospective basis for the provision of basic health services, except that a health maintenance organization may [obtain insurance or make other arrangements] (A) *obtain insurance or make other arrangements* for the cost of providing to any member basic health services the aggregate value of which exceeds \$5,000 in any year, (B) *obtain insurance or make other arrangements* for the cost of basic health services provided to its members other than through the organization because medical necessity required their provision before they could be secured through the organization, [and] (C) *obtain insurance or make other arrangements* for not more than 90 per centum of the amount by which its costs for any of its fiscal years exceed 115 per centum of its income for such fiscal year, and (D) *make arrangements with physicians or other health professionals, health care insti-*

tutions, to assume all or part of the financial risk on a prospective basis for the provision of basic health services by the physicians or other health professionals or through the institutions;

(3)(A) enroll persons who are broadly representative of the various age, social, and income groups within the area it serves, except that in the case of a health maintenance organization which has a medically underserved population located (in whole or in part) in the area it serves, not more than 75 per centum of the members of that organization may be enrolled from the medically underserved population unless the area in which such population resides is also a rural area (as designated by the Secretary), and (B) carry out enrollment of members who are entitled to medical assistance under a State plan approved under title XIX of the Social Security Act in accordance with procedures approved under regulations promulgated by the Secretary;

[(4) have an open enrollment period in accordance with the provisions of subsection (d);]

[(5)] (4) not expel or refuse to re-enroll any member because of his health status or his requirements for health services;

[(6)(A) in the case of a private health maintenance organization, be organized in such a manner that assures that (i) at least one-third of the membership of the policymaking body of the health maintenance organization will be members of the organization, and (ii) there will be equitable representation on such body of members from medically underserved populations served by the organization, and (B) in the case of a public health maintenance organization, have an advisory board to the policymaking body of the public entity operating the organization which board meets the requirements of clause (A) of this paragraph and to which may be delegated policymaking authority for the organization;]

[(7)] (5) be organized in such a manner that provides meaningful procedures for hearing and resolving grievances between the health maintenance organization (including the medical group or groups and other health delivery entities providing health services for the organization) and the members of the organization;

[(8)] (6) have organizational arrangements, established in accordance with regulations of the Secretary, for an ongoing quality assurance program for its health services which program (A) stresses health outcomes, and (B) provides review by physicians and other health professionals of the process followed in the provision of health services;

[(9)] (7) provide medical social services for its members and encourage and actively provide for its members health education services, education in the appropriate use of health services, and education in the contribution each member can make to the maintenance of his own health;

[(10)] (8) provide, or make arrangements for, continuing education for its health professional staff; and

[(11)] (9) provide, in accordance with regulations of the Secretary (including safeguards concerning the confidentiality of the doctor-patient relationship), an effective procedure for de-

veloping, compiling, evaluating, and reporting to the Secretary, statistics and other information (which the Secretary shall publish and disseminate on an annual basis and which the health maintenance organization shall disclose, in a manner acceptable to the Secretary, to its members and the general public) relating to (A) the cost of its operations, (B) the patterns of utilization of its services, (C) the availability, accessibility, and acceptability of its services, (D) to the extent practical, developments in the health status of its members, and (E) such other matters as the Secretary may require.

[(d)(1)(A) A health maintenance organization which—

[(i) has for at least 5 years provided comprehensive health services on a prepaid basis, or

[(ii) has an enrollment of at least 50,000 members, shall have at least once during each fiscal year next following a fiscal year in which it did not have a financial deficit an open enrollment period (determined under subparagraph (B)) during which it shall accept individuals for membership in the order in which they apply for enrollment and, except as provided in paragraph (2), without regard to preexisting illness, medical condition, or degree of disability.

[(B) An open enrollment period for a health maintenance organization shall be the lesser of—

[(i) 30 days, or

[(ii) the number of days in which the organization enrolls a number of individuals at least equal to 3 percent of its total net increase in enrollment (if any) in the fiscal year preceding the fiscal year in which such period is held.

For the purpose of determining the total net increase in enrollment in a health maintenance organization, there shall not be included any individual who is enrolled in the organization through a group which had a contract for health care services with the health maintenance organization at the time that such health maintenance organization was determined to be a qualified health maintenance organization under section 1310.

[(2) Notwithstanding the requirements of paragraph (1) of health maintenance organization shall not be required to enroll individuals who are confined to an institution because of chronic illness, permanent injury, or other infirmity which would cause economic impairment to the health maintenance organization if such individuals were enrolled.

[(3) A health maintenance organization may not be required to make the effective date of benefits for individuals enrolled under this subsection less than 90 days after the date of enrollment.

[(4) The Secretary may waive the requirements of this subsection for a health maintenance organization which demonstrates that compliance with the provisions of this subsection would jeopardize its economic viability in its service area.]

DEFINITIONS

SEC. 1302. For purposes of this title:

(1) The term "basic health services" means—

(A) physician services (including consultant and referral services by a physician);

(B) inpatient and outpatient hospital services;

(C) medically necessary emergency health services;

[(D)] short-term (not exceed twenty visits), outpatient evaluative and crisis intervention mental health services;

[(E)] medical treatment and referral services (including referral services to appropriate ancillary services) for the abuse of or addiction to alcohol and drugs;]

[(F)] (D) diagnostic laboratory and diagnostic and therapeutic radiologic services;

[(G)] (E) home health services; and

[(H)] (F) preventive health services (including (i) immunizations, (ii) well-child care from birth, (iii) periodic health evaluations for adults, (iv) voluntary family planning services, (v) infertility services, and (vi) children's eye and ear examinations conducted to determine the need for vision and hearing correction).

Such term does not include a health service which the Secretary, upon application of a health maintenance organization, determines is unusual and infrequently provided and not necessary for the protection of individual health. The Secretary shall publish in the Federal Register each determination made by him under the preceding sentence. If a service of a physician described in the preceding sentence may also be provided under applicable State law by a dentist, optometrist, podiatrist, or other health care personnel a health maintenance organization may provide such service through a dentist, optometrist, podiatrist, or other health care personnel (as the case may be) licensed to provide such service. For purposes of this paragraph, the term "home health services" means health services provided at a member's home by health care personnel, as prescribed or directed by the responsible physician or other authority designated by the health maintenance organization. A health maintenance organization is authorized, in connection with the prescription of drugs, to maintain, review, and evaluate (in accordance with regulations of the Secretary) a drug use profile of its members receiving such service, evaluate patterns of drug utilization to assure optimum drug therapy, and provide for instruction of its members and of health professionals in the use of prescription and non-prescription drugs. *An employer subject to section 1310 may require as a condition to the offering pursuant to such section of membership in a health maintenance organization that the health maintenance organization offer, for such payments determined by the health maintenance organization, short-term (not to exceed twenty visits), out-patient evaluative and crisis intervention mental health services and medical treatment and referral services (including referral services to appropriate ancillary services) for the abuse of or addiction to alcohol and drugs.*

(2) The term "supplemental health services" [means—

[(A)] services of facilities for intermediate and long-term care;

[(B)] vision care not included as a basic health service;

[(C)] dental services not included as a basic health service;

[(D)] mental health services not included as a basic health service under paragraph (1)(D);

[(E)] long-term physical medicine and rehabilitative services (including physical therapy);

[(F) the provision of prescription drugs prescribed in the course of the provision by the health maintenance organization of a basic health service or a service described in the preceding subparagraphs of this paragraph; and

[(G) other health services which are not included as basic health services and which have been approved by the Secretary for delivery as supplemental health services.] *means any health service which is not included as a basic health service under paragraph (1) of this section.*

If a [service of a physician described in the preceding sentence] *health service provided by a physician* may also be provided under applicable State law by a dentist, optometrist, podiatrist, or other health care personnel, a health maintenance organization may provide such service through an optometrist, dentist, podiatrist, or other health care personnel (as the case may be) licensed to provide such service. A health maintenance organization is authorized, in connection with the prescription or provision of prescription drugs, to maintain, review, and evaluate (in accordance with regulations of the Secretary) a drug use profile of its members receiving such services, evaluate patterns of drug utilization to assure optimum drug therapy, and provide for instruction of its members and of health professionals in the use of prescription and non-prescription drugs.

* * * * *

[(7) The term “medically underserved population” means the population of an urban or rural area designated by the Secretary as an area with a shortage of personal health services or a population group designated by the Secretary as having a shortage of such services. Such a designation may be made by the Secretary only after consideration of the comments (if any) of (A) each State health planning and development agency which covers (in whole or in part) such urban or rural area or the area in which such population group resides, and (B) each health systems agency designated for a health service area which covers (in whole or in part) such urban or rural area or the area in which such population group resides.

[(8) The term “community rating system” means a system of fixing rates of payments for health services. Under such a system rates of payments may be determined on a per-person or per-family basis and may vary with the number of persons in a family, but except as otherwise authorized in the next sentence, such rates must be equivalent for all individuals and for all families of similar composition. The following differentials in rates of payments may be established under such system:

[(A) Nominal differentials in such rates may be established to reflect differences in marketing costs and the different administrative costs of collecting payments from the following categories of members:

- [(i) Individual members (including their families).
- [(ii) Small groups of members (as determined under regulations of the Secretary).
- [(iii) Large groups of members (as determined under regulations of the Secretary).

[(B) Nominal differentials in such rates may be established to reflect the compositing of the rates of payment in a systematic manner to accommodate group purchasing practices of the various employers.

[(C) Differentials in such rates may be established for members enrolled in a health maintenance organization pursuant to a contract with a governmental authority under section 1079 or 1086 of the title 10, United States Code, or under any other governmental program (other than the health benefits program authorized by chapter 89 of title 5, United States Code) or any health benefits program for employees of States, political subdivision of States, and other public entities.]

(7)(A) *The term "community rating system" means the systems, described in subparagraphs (B) and (C), of fixing rates of payments for health services. A health maintenance organization may fix its rates of payments under the system described in subparagraph (B) of (C) but not under both systems.*

(B) *A system of fixing rates of payment for health services may provide that the rates shall be fixed on a per-person or per-family basis and may authorize the rates to vary with the number of persons in a family, but, except as authorized in subparagraph (D), such rates must be equivalent for all individuals and for all families of similar composition.*

(C) *A system of fixing rates of payment for health services may provide that the rates shall be fixed for individuals and families by groups. Except as authorized in subparagraph (D), such rates must be equivalent for all individuals in the same group and for all families of similar composition in the same group. If a health maintenance organization is to fix rates of payment for individuals and families by groups, it shall—*

(i) classify all of the members of the organization into classes based on factors which the health maintenance organization determines predict the differences in the use of health services by the individuals or families in each class and which have not been disapproved by the Secretary,

(ii) determine its revenue requirements for providing services to the members of each class established under clause (i), and

(iii) fix the rates of payment for the individuals and families of a group on the basis of a composite of the organization's revenue requirements determined under clause (ii) for providing services to them as members of the classes established under clause (i).

The Secretary shall review the factors used by each health maintenance organization to establish classes under clause (i). If the Secretary determines that any such factor may not reasonably be used to predict the use of the health services by individuals and families, the Secretary shall disapprove such factor for such purpose.

(D) *The following differentials in rates of payments may be established under the systems described in subparagraphs (B) and (C):*

(i) Nominal differentials in such rates may be established to reflect differences in marketing costs and the different administrative costs of collecting payments from the following categories of members:

(I) Individual members (including their families).

(II) *Small groups of members (as determined under regulations of the Secretary).*

(III) *Large groups of members (as determined under regulations of the Secretary).*

(ii) *Nominal differentials in such rates may be established to reflect the compositing of the rates of payment in a systematic manner to accommodate group purchasing practices of the various employers.*

(iii) *Differentials in such rates may be established for members enrolled in a health maintenance organization pursuant to a contract with a governmental authority under section 1079 or 1086 of the title 10, United States Code, or under any other governmental program (other than the health benefits program authorized by chapter 89 of title 5, United States Code) or any health benefits program for employees of States, political subdivision of States, and other public entities.*

[(9)] (8) The term "non-metropolitan area" means an area no part of which is within an area designated as a standard metropolitan statistical area by the Office of Management and Budget and which does not contain a city whose population exceeds fifty thousand individuals.

GRANTS AND CONTRACTS FOR FEASIBILITY SURVEYS

SEC. 1303. (a) * * *

* * * * *

[(c)] In considering applications for grants and contracts under this section, the Secretary shall give priority to an application which contains or is supported by assurances satisfactory to the Secretary that at the time the health maintenance organization for which such application or proposal is submitted first becomes operational not less than 30 per centum of its members will be members of a medically underserved population.】

[(d)] (c)(1) Except as provided in paragraph (2), the following limitations apply with respect to grants and contracts made under this section:

(A) If a project has been assisted with a grant or contract under subsection (a), the Secretary may not make any other grant or enter into any other contract under this section for such project.

(B) Any project for which a grant is made or contract entered into must be completed within twelve months from the date the grant is made or contract entered into.

(2) The Secretary may make not more than one additional grant or enter into not more than one additional contract for a project for which a grant has previously been made or a contract previously entered into, and he may permit additional time (up to twelve months) for completion of the project if he determines that the additional grant or contract (as the case may be), or additional time, or both, is needed to adequately complete the project.

[(e)] (d) The amount to be paid by the United States under a grant made, or contract entered into, under subsection (a) shall be determined by the Secretary, except that (1) the amount to be paid by the United States under any single grant or contract for any project may not exceed \$75,000, and (2) the aggregate of the

amounts to be paid by the United States for any project under such subsection under grants or contracts, or both, may not exceed the greater of (A) 90 per centum of the costs of such project (as determined under regulations of the Secretary), or (B) in the case of a project for a health maintenance organization which will serve a medically underserved population, such greater percentage (up to 100 per centum) of such costs as the Secretary may prescribe if he determines that the ceiling on the grants and contracts for such project should be determined by such greater percentage.

[(f)] (e) Payments under grants under this section may be made in advance or by way of reimbursement and at such intervals and on such conditions as the Secretary finds necessary.

[(g)] (f) Contracts may be entered into under this section without regard to sections 3648 and 3709 of the Revised Statutes (31 U.S.C. 529; 41 U.S.C. 5).

[(h)] (g) Payments under grants and contracts under this section shall be made from appropriations made under section 1309(a).

[(i) Of the sums appropriated for any fiscal year under section 1309(a) for grants and contracts under this section, not less than 20 per centum shall be set aside and obligated in such fiscal year for projects (1) to determine the feasibility of developing and operating or expanding the operation of health maintenance organizations which the Secretary determines may reasonably be expected to have after their development or expansion not less than 66 per centum of their membership drawn from residents of non-metropolitan areas, and (2) the applications for which meet the requirements of this title for approval. Sums set aside in any fiscal year for projects described in the preceding sentence but not obligated in such fiscal year for grants and contracts under this section because of a lack of applicants for projects meeting the requirements of such sentence shall remain available for obligation under this section in the succeeding fiscal year for any project, with priority being given to projects described in clause (1) of such sentence.】

GRANTS, CONTRACTS, AND LOAN GUARANTEES FOR PLANNING AND FOR INITIAL DEVELOPMENT COSTS

SEC.1304. (3) * * *

* * * * *

[(d) In considering applications for grants and contracts under this section, the Secretary shall give priority to an application which contains or is supported by assurances satisfactory to the Secretary that at the time the health maintenance organization for which such application is submitted first becomes operational not less than 30 per centum of its members will be members of a medically underserved population. In considering applications for loan guarantees under this section, the Secretary shall give special consideration to applications for projects for health maintenance organizations which will serve medically underserved populations.】

[(e)] (d)(1) Except as provided in paragraph (2), the following limitations apply with respect to grants, loan guarantees, and contracts made under subsection (a) of this section:

(A) If a planning project has been assisted with grant, loan guarantee, or contract under subsection (a), the Secretary may not make any other planning grant or loan guarantee or enter

into any other planning contract for such project under this section.

(B) Any project for which a grant or loan guarantee is made or contract entered into must be completed within twelve months from the date the grant or loan guarantee is made or contract entered into.

(2) The Secretary may not make more than one additional grant or loan guarantee or enter into not more than one additional contract for a planning project for which a grant or loan guarantee has previously been made or a contract previously entered into, and he may permit additional time (up to twelve months) for completion of the project if he determines that the additional grant, loan guarantee, or contract (as the case may be), or additional time, or both, is needed to adequately complete the project.

[(f)] (e)(1) The amount to be paid by the United States under a grant made, or contract entered into, under subsection (a) for a planning project, and (except as provided in paragraph (3) of this subsection) the amount of principal of a loan for a planning project which may be guaranteed under such subsection, shall be determined by the Secretary, except that (A) the amount to be paid by the United States under any single grant or contract, and the amount of principal of any single loan guaranteed under such subsection, may not exceed \$200,000, and (B) the aggregate of the amounts to be paid for any project by the United States under grants or contracts, or both, under such subsection, and the aggregate amount of principal of loans guaranteed under such subsection for any project, may not exceed the greater of (i) 90 per centum of the cost of such project (as determined under regulations of the Secretary), or (ii) in the case of a project for a health maintenance organization which will serve a medically underserved population, such greater percentage (up to 100 per centum) of such cost as the Secretary may prescribe if he determines that the ceiling on the grants, contracts, and loan guarantees (or any combination thereof) for such project should be determined by such greater percentage.

(2) Except as provided in paragraph (3), the amount to be paid by the United States under a grant made, or contract entered into, under subsection (b) for an initial development project, and the amount of principal of a loan for an initial development project which may be guaranteed under such subsection, shall be determined by the Secretary; except that the amounts to be paid by the United States for any initial development project under grants or contracts, or both, under such subsection, and the aggregate amount of principal of loans guaranteed under such subsection for any project, may not exceed the lesser of—

(A) \$1,000,000 through September 30, 1979, and \$2,000,000 thereafter, or

(B) an amount equal to the greater of (i) 90 per centum of the cost of such project (as determined under regulations of the Secretary), or (ii) in the case of a project for a health maintenance organization which will serve a medically underserved population, such greater percentage (up to 100 per centum) of such cost as the Secretary may prescribe if he determines that the ceiling on the grants, contracts, and loan guarantees (or

any combination thereof) for such project should be determined by such greater percentage.

(3) The cumulative total of grants made to, contracts entered into with, and principal of loans guaranteed for, a health maintenance organization under subsection (b) of this section may not exceed \$1,000,000 through September 30, 1979, or \$2,000,000 thereafter. The cumulative total of the principal of the loans outstanding at any time with respect to which guarantees have been issued under this section may not exceed such limitations as may be specified in appropriation Acts.

[(g)] (f) Payments under grants under this section may be made in advance or by way of reimbursement and at such intervals and on such conditions as the Secretary finds necessary.

[(h)] (g) Contracts may be entered into under this section without regard to sections 3648 and 3709 of the Revised Statutes (31 U.S.C. 529; 41 U.S.C. 5).

[(i)] (h) Payments under grants and contracts under this section shall be made from appropriations under section 1309(a).

[(j)] (i) Loan guarantees under subsection (a)(2) for planning projects and loan guarantees under subsection (b)(1)(B) for initial development projects may be made through the fiscal year ending September 30, [1981.] 1984.

[(k)(1)] Of the sums appropriated for any fiscal year under section 1309(a) for grants and contracts under subsection (a) of this section, not less than 20 per centum shall be set aside and obligated in such fiscal year for projects (A) to plan the establishment or expansion of health maintenance organizations which the Secretary determines may reasonably be expected to have after their establishment or expansion not less than 66 per centum of their membership drawn from residents of non-metropolitan areas, and (B) the applications for which meet the requirements of this title for approval. Sums set aside in any fiscal year for projects described in the preceding sentence but not obligated in such fiscal year for grants and contracts under subsection (a) of this section because of a lack of applicants for projects meeting the requirements of such sentence shall remain available for obligation under such subsection in the succeeding fiscal year for any project, with priority being given to projects described in clause (A) of such sentence.

[(2)] Of the sums appropriated for any fiscal year under section 1309(a) for grants and contracts under subsection (b) of this section, not less than 20 per centum shall be set aside and obligated in such fiscal year for projects (A) for the initial development of health maintenance organizations which the Secretary determines may reasonably be expected to have after their initial development not less than 66 per centum of their membership drawn from residents of non-metropolitan areas, and (B) the applications for which meet the requirements of this title for approval. Sums set aside in any fiscal year for projects described in the preceding sentence but not obligated in such fiscal year for grants and contracts under subsection (b) of this section because of a lack of applicants for projects meeting the requirements of such sentence shall remain available for obligation under such subsection in the succeeding fiscal year for any project, with priority being given to projects described in clause (A) of such sentence.]

LOANS AND LOAN GUARANTEES FOR INITIAL COSTS OF OPERATION

SEC. 1305. (a) The Secretary may—

(1) make loans to public or **[nonprofit]** private health maintenance organizations to assist them in meeting the amount by which their costs of operation during a period not to exceed the first sixty months of their operation exceed their revenues in that period;

(2) make loans to public or **[nonprofit]** private health maintenance organizations to assist them in meeting the amount by which their costs of operation, which the Secretary determines are attributable to significant expansion in their membership or area served and which are incurred during a period not to exceed the first sixty months of their operation after such expansion, exceed their revenues in that period which the Secretary determines are attributable to such expansion; and

[(3) guarantee to non-Federal lenders payment of the principal of and the interest on loans made to—

[(A) nonprofit private health maintenance organizations for the amounts referred to in paragraph (1) or (2), or

[(B) other private health maintenance organizations for such amounts but only if the health maintenance organization will serve a medically underserved population.]]

(3) guarantee to non-Federal lenders payment of the principal of and the interest on loans made to private health maintenance organizations for the amounts referred to in paragraphs (1) and (2).

No loan or loan guarantee may be made under this subsection for the costs of operation of a health maintenance organization unless the Secretary determines that the organization has made all reasonable attempts to meet such costs.

[(b)(1) Except as provided in paragraph (2), the aggregate amount of principal of loans made or guaranteed, or both, under this section for a health maintenance organization may not exceed \$2,500,000 (or \$4,500,000 if the Secretary makes a written determination that such loans or loan guarantees are necessary to preserve the fiscally sound operation of the health maintenance organization and to protect against the risk of insolvency of the health maintenance organization and, within 30 days of the making of such loans or loan guarantees, furnishes the Committee on Human Resources of the Senate and the Committee on Interstate and Foreign Commerce of the House of Representatives with written notification of the making of the loans or loan guarantees and a copy of the written determination made with respect to the loans or loan guarantees and the reasons for the determination) through September 30, 1979, and \$4,500,000 thereafter. In any twelve-month period the amount disbursed to a health maintenance organization under this section (either directly by the Secretary or by an escrow agent under the terms of an escrow agreement or by a lender under a loan guaranteed under this section) may not exceed \$1,000,000 (or \$2,000,000 if the Secretary makes a written determination that such disbursements are necessary to preserve the fiscally sound operation of the health maintenance organization and protect against the risk of insolvency of the health maintenance organization and, within 30 days of such disbursement, furnishes the Committee on

Human Resources of the Senate and the Committee on Interstate and Foreign Commerce of the House of Representatives with written notification of the making of the disbursement and a copy of the written determination made with respect to it and the reasons for the determination) through September 30, 1979, and \$2,000,000 thereafter.】

(b)(1) Except as provided in paragraph (2), the aggregate amount of principal of loans made or guaranteed, or both, under subsection (a) for a health maintenance organization may not exceed \$7,000,000. In any twelve-month period the amount disbursed to a health maintenance organization under this section (either directly by the Secretary, by an escrow agent under the terms of an escrow agreement, or by a lender under a guaranteed loan) may not exceed \$3,000,000.

(d) No loan may be made or guaranteed under this section after September 30, 【1981】 1986.

【(e) Of the sums used for loans under this section in any fiscal year from the loan fund established under section 1308(e), not less than 20 per centum shall be used for loans for projects (1) for the initial operation of health maintenance organizations which the Secretary determines have not less than 66 per centum of their membership drawn from residents of nonmetropolitan areas, and (2) the applications for which meet the requirements of this title for approval.

【(f) In considering applications for loan guarantees under this section, the Secretary shall give special consideration to applications for health maintenance organizations which will serve medically underserved populations.】

LOANS AND LOAN GUARANTEES FOR ACQUISITION AND CONSTRUCTION OF AMBULATORY HEALTH CARE FACILITIES

SEC. 1305A. (a) the Secretary may—

(1) make loans, from the fund established under section 1308(e), to public and 【nonprofit】 private health maintenance organizations for projects for the acquisition or construction of ambulatory health care facilities and for the acquisition of equipment for facilities acquired or constructed under a loan made under this paragraph; and

(2) guarantee to—

【(A) non-Federal lenders for their loans to nonprofit private health maintenance organizations for projects described in paragraph (1) and to private health maintenance organizations for such projects which will serve medically underserved populations, and

【(B) the Federal Financing Bank for its loans to nonprofit private health maintenance organizations for projects described in paragraph (1) and to private health maintenance organizations for such projects which will serve medically underserved populations,
the payment of principal and interest on such loans.】

(2) guarantee to non-Federal lenders for their loans to private health maintenance organizations for projects described in paragraph (1) the payment of principal and interest on such loans.

(b) No loan may be made to a health maintenance organization and no loan to a health maintenance may be guaranteed under subsection (a) unless the application of the health maintenance organization for such loan or loan guarantee contains—

(1) certification by an independent auditor that, at the time the application is made, the revenues of the health maintenance organization exceed its costs of operation;

(2) assurances satisfactory to the Secretary that—

(A) if the application is for a loan, the health maintenance organization is unable to secure a loan, at the rate of interest prevailing in the area in which the organization is located, from non-Federal lenders for the project with respect to which the application is submitted, or, if the application is for a loan guarantee, the health maintenance organization would be unable to secure a loan from such lenders for such project without the loan guarantee; and

(B) during the period of the loan or loan guarantee the revenues of the health maintenance organization will exceed its costs of operation (including the cost of repaying the loan made or guaranteed under this section).

[(b)] (c)(1) Except as provided in paragraph (2), the aggregate amount of principal of loans made or guaranteed, or both, under subsection (a) for an ambulatory health care facility may not exceed \$2,500,000.

(2) The cumulative total of the principal of the loans outstanding at any time which have been directly made or with respect to which guarantees have been issued under subsection (a) may not exceed such limitations as may be specified in appropriation Acts.

(3) The authority of the Secretary to make loans under subsection (a) shall be effective for any fiscal year only to such extent or in such amounts as are provided in advance in appropriation Acts.

[(c)] (d) For purposes of this section—

(1) the term “ambulatory health care facility” means a health care facility for the provision of diagnostic, treatment, and prevention services to ambulatory patients; and

(2) the term “construction” means the (A) construction of new facilities, (B) alterations, expansion, remodeling, replacement, and renovation of existing facilities, (C) cost of offsite improvements in connection with an activity described in clause (A) or (B), and (D) cost of the acquisition of land in connection with an activity described in clause (A), (B), or (C).

APPLICATION REQUIREMENTS

SEC. 1306. (a) No grant, contract, loan, or loan guarantee may be made under this title unless an application therefor has been submitted to and approved by the Secretary.

(b) The Secretary may not approve an application for a grant, contract, loan, or loan guarantee under this title unless—

(1) * * *

(3) the application contains satisfactory specification of the existing or anticipated (A) population group or groups to be served by the proposed or existing health maintenance organization described in the application, (B) membership of such organization, (C) methods, terms, and periods of the enrollment

of members of such organization, (D) estimated costs per member of the health and educational services to be provided by such organization and the nature of such costs, (E) sources of professional services for such organization, and organizational arrangements of such organization for providing health and educational services, (F) organizational arrangements of such organization for an ongoing quality assurance program in conformity with the requirements of section 1301(c), (G) sources of prepayment and other forms of payment for the services to be provided by such organization, (H) facilities, and additional capital investments and sources of financing therefor, available to such organization to provide the level and scope of services proposed, (I) administrative, managerial, and financial arrangements and capabilities of such organization, [(J) role for members in the planning and policymaking for such organization,] [(K)] (J) grievance procedures for members of such organization, and [(L)] (K) evaluations of the support for and acceptance of such organization by the population to be served, the sources of operating support, and the professional groups to be involved or affected thereby;

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ADMINISTRATION OF ASSISTANCE PROGRAMS

SEC. 1307. (a)(1) * * *

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(c) If in any fiscal year the funds appropriated under section 1309 are insufficient to fund all applications approved under this title for that fiscal year, the Secretary shall [after applying the applicable priorities under sections 1303 and 1304,] give priority to the funding of applications for project which the Secretary determines are the most likely to be economically viable.

* * * * *

[(e) In any fiscal year no loan guarantee may be made for a private health maintenance organization (other than a private nonprofit health maintenance organization) under this title if the making of such guarantee would cause the cumulative total of the principal of the loans guaranteed; for private health maintenance organizations (other than private nonprofit health maintenance organizations) under this title in such fiscal year to exceed the amount of grant and contract funds obligated under this title in such fiscal year; except that this subsection shall not apply if the amount of grant and contract funds obligated under this title in such fiscal year equals the sums appropriated under section 1309 for grants and contracts for such fiscal year.]

GENERAL PROVISIONS RELATING TO LOAN GUARANTEES AND LOANS

SEC. 1308. (a)(1) * * *

* * * * *

(b)(1) The Secretary may not approve an application for a loan under this title unless—

(A) the Secretary is reasonably satisfied that the applicant therefor will be able to make payments of principal and interest thereon when due, and

(B) the applicant provides the Secretary with reasonable assurances that there will be available to it such additional funds as may be necessary to complete the project or undertaking with respect to which such loan is requested.

(2) Any loan made under this title shall (A) have such security, (B) have such maturity date, (C) be repayable in such installments, [(D) bear interest at a rate comparable to the current rate of interest prevailing, on the date the loan is made, with respect to marketable obligations of the United States of comparable maturities, adjusted to provide for appropriate administrative charge, and] (D) *on the date the loan is made, bear interest at a rate comparable to the rate of interest prevailing on such date with respect to marketable obligations of the United States of comparable maturities, adjusted to provide for appropriate administrative charges, and* (E) be subject to such other terms and conditions (including provisions for recovery in case of default), as the Secretary determines to be necessary to carry out the purposes of this title while adequately protecting the financial interests of the United States. *On the date disbursements are made under a loan after the initial disbursement under the loan, the Secretary may change the rate of interest on the amount of the loan disbursed on that date to a rate which is comparable to the rate of interest prevailing on the date the subsequent disbursement is made with respect to marketable obligations of the United States of comparable maturities, adjusted to provide for appropriate administrative charges.*

* * * * *

AUTHORIZATIONS OF APPROPRIATIONS

Sec. 1309. [(a) For the purpose of making payments under grants and contracts under sections 1303, 1304(a), 1304(b), and 1317, there are authorized to be appropriated \$25,000,000 for the fiscal year ending June 30, 1974, \$55,000,000 for the fiscal year ending June 30, 1975, \$40,000,000 for the fiscal year ending June 30, 1976, \$45,000,000 for the fiscal year ending September 30, 1977, \$45,000,000 for the fiscal year ending September 30, 1978, \$31,000,000 for the fiscal year ending September 30, 1979, \$65,000,000 for the fiscal year ending September 30, 1980, and \$68,000,000 for the fiscal year ending September 30, 1981.] (a) *There are authorized to be appropriated such sums as may be necessary for the fiscal year ending September 30, 1982, and the two succeeding fiscal years for grants and contracts under section 1304(a) and 1304(b). No funds appropriated under this subsection may be obligated for a grant or contract under section 1304(a) for an entity unless that entity received a grant or contract under section 1303 or section 1304(a) which provided funds for the fiscal year ending September 30, 1981, and no funds appropriated under this subsection may be obligated for a grant or contract under section 1304(b) for an entity unless that entity received a grant or contract under section 1303 or section 1304(a) or 1304(b) which provided funds for such fiscal year. For grants and contracts under section 1317 there are authorized to be appropriated \$1,000,000 for the fiscal year ending*

September 30, 1982, \$1,000,000 for the fiscal year ending September 30, 1983, and \$1,000,000 for the fiscal year ending September 30, 1984.

[(b) There is authorized to be appropriated to the loan fund established under section 1308(e) \$75,000,000 in the aggregate for the fiscal years ending June 30, 1974, and June 30, 1975.]

(b) To assure that the loan fund established under section 1308(e) has a balance of at least \$5,000,000 at the end of each fiscal year and to meet the obligations of the loan fund resulting from defaults on loans made from the fund and to meet the other obligations of the fund, there is authorized to be appropriated to the loan fund for the fiscal year ending September 30, 1982, and for the next two fiscal years \$40,000,000 or such greater amount as may be necessary to assure such balance and meet such obligations.

EMPLOYEE'S HEALTH BENEFITS PLANS

Sec. 1310. (a)(1) * * *

(b)(1) If there is more than one qualified health maintenance organization which is engaged in the provisions of basic and supplemental health services in the area in which the employees of an employer subject to subsection (a) reside and if—

[(1)] (A) one or more of such organizations provides *more than one-half of its* basic health services which are provided by physicians through physicians or other health professionals who are members of the staff of the organization or a medical group (or groups), and

[(2)] (B) one or more of such organizations provides *its* basic health services which are provided by physicians through [(A)] (i) an individual practice association (or associations), [or (B)] (ii) individual physicians and other health professionals under contract with the organization, or (iii) a combination of such association (or associations), medical group (or groups), staff, and individual physicians and other health professionals under contract with the organization,

then of the qualified health maintenance organizations included in a health benefits plan of such employer pursuant to subsection (a) at least one shall be an organization which provides basic health services as described in [clause (1)] subparagraph (A) and at least one shall be an organization which provides basic health services as described in [clause (2)] subparagraph (B).

(2) If an employer subject to subsection (a) includes in a health benefits plan a health maintenance organization—

(A) which is owned or controlled by—

(i) a commercial insurance carrier which provides health insurance to, or

(ii) a nonprofit carrier which provides hospital service benefits or medical or surgical benefits, or both benefits, to, a substantial percentage of the residents of the service area of the health maintenance organization who have health insurance with a commercial insurance carrier or arrangements to receive such benefits from such a nonprofit carrier, and

(B) which provides basic health services through an organizational arrangement described in subparagraph (A) or (B) of paragraph (1),

the employer shall include in the plan an additional health maintenance organization which has residing in its service area at least 25 of the employees of the employer, which is not so owned or controlled, and which provides basic health services through an organizational arrangement described in the subparagraph descriptive of the owned or controlled health maintenance organization unless there is not such an additional organization.

* * * * *

(f) For purposes of this section, the term "employer" does not include (1) the Government of the United States, the government of the District of Columbia or any territory or possession of the United States, a State or any political subdivision thereof, or any agency or instrumentality (including the United States Postal Service and Postal Rate Commission) of any of the foregoing, *except that such term includes a nonappropriated fund instrumentality described by section 2105(c) of title 5, United States Code*; or (2) a church, convention or association of churches, or any organization operated, supervised or controlled by a church, convention or association of churches which organization (A) is an organization described in section 501(c)(3) of the Internal Revenue Code of 1954, and (B) does not discriminate (i) in the employment, compensation, promotion, or termination of employment of any personnel, or (ii) in the extension of staff or other privileges to any physician or other health personnel, because such persons seek to obtain or obtained health care, or participate in providing health care, through a health maintenance organization.

* * * * *

[PROGRAM EVALUATION

[SEC. 1314. (a) The Comptroller General shall evaluate the operations of at least ten or one-half (whichever is greater) of the health maintenance organizations for which assistance was provided under sections 1303, 1304, and 1305, and which, by December 31, 1976, have been designated by the Secretary under section 1310(d) as qualified health maintenance organizations. The Comptroller General shall report to the Congress the results of the evaluation by June 30, 1978. Such report shall contain findings—

[(1) with respect to the ability of the organizations evaluated to operate on a fiscally sound basis without continued Federal financial assistance,

[(2) with respect to the ability of such organizations to meet the requirements of section 1301(c) respecting their organization and operation,

[(3) with respect to the ability of such organizations to provide basic and supplemental health services in the manner prescribed by section 1301(b),

[(4) with respect to the ability of such organizations to include indigent and high-risk individuals in their membership, and

[(5) with respect to the ability of such organizations to provide services to medically underserved populations.

[(b) The Comptroller General shall also conduct a study of the economic effects on employers resulting from their compliance with

the requirements of section 1310. The Comptroller General shall report to the Congress the results of such study not later than thirty-six months after the date of the enactment of this title.

[(c) The Comptroller General shall evaluate (1) the operations of distinct categories of health maintenance organizations in comparison with each other, (2) health maintenance organizations as a group in comparison with alternative forms of health care delivery, and (3) the impact that health maintenance organizations, individually, by category, and as a group, have on the health of the public. The Comptroller General shall report to the Congress the results of such evaluation not later than thirty-six months after the date of the enactment of this title.

[(d) The Comptroller General shall evaluate the adequacy and effectiveness of the policies and procedures of the Secretary for the management of grant and loan programs established by this title and the adequacy of the amounts of assistance available under such programs and shall report to the Congress the results of such evaluation not later than May 1, 1979.]

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FINANCIAL DISCLOSURE

SEC. 1318. (a) Each health maintenance organization shall, in accordance with regulations of the Secretary, report to the Secretary financial information which shall include the following:

(1) Such information as the Secretary may require demonstrating that the health maintenance organization has a fiscally sound operation.

[(2) The information required to be reported under section 1124 of the Social Security Act by disclosing entities and the information required to be supplied under section 1902(a)(38) of such Act.]

(2) A copy of the report, if any, filed with the Health Care Financing Administration containing the information required to be reported under section 1124 of the Social Security Act by disclosing entities and the information required to be supplied under section 1902(a)(38) of such Act.

(3) A description of transactions, as specified by the Secretary, between the health maintenance organization and a party in interest. Such transaction shall include—

(A) any sale or exchange, or leasing of any property between the health maintenance organization and a party in interest;

[(B) any furnishing for consideration of goods, services (including management services, but excluding health services provided to members by staff, medical group (or groups), individual practice association (or associations), or any combination thereof), or facilities between the health maintenance organization and a party in interest; and]

(B) any furnishing for consideration of goods, services (including management services), or facilities between the health maintenance organization and a party in interest, but not including salaries paid to employees for services provided in the normal course of their employment and health services provided to members by hospitals and other

providers and by staff, medical group (or groups), individual practice association (or associations), or any combination thereof; and

* * * * *

(b) For the purposes of this section the term "party in interest" means:

(1) any director, office, partner, or *managing* employee of a health maintenance organization, any person who is directly or indirectly the beneficial owner of more than 5 per centum of the equity of the organization, any person who is the beneficial owner of a mortgage, deed of trust, note, or other interest secured by, and valuing more than 5 per centum of the health maintenance organization, and, in the case of a health maintenance organization organized as a nonprofit corporation, an incorporator or member of such corporation under applicable State corporation law;

* * * * *

(4) [any member of the immediate family] *any spouse, child, or parent* of an individual described in paragraph (1).

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PART C—STATE HEALTH PLANNING AND DEVELOPMENT

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CERTIFICATE OF NEED PROGRAM

Sec. 1527. (a) * * *

(b)(1) Under the program a State shall not require a certificate of need for the offering of an inpatient institutional health service or the acquisition of major medical equipment for the provision of an inpatient institutional health service or the obligation of a capital expenditure for the provision of an inpatient institutional health service by—

(A) a health maintenance organization or a combination of health maintenance organizations if [(i) the organization or combination of organizations has, in the service area of the organization or the service areas of the organizations in the combination, an enrollment of at least 50,000 individuals] [(ii)] (i) the facility in which the service will be provided is or will be geographically located so that the service will be reasonably accessible to [such enrolled individuals] *individuals enrolled in such organization or organizations*, and [(iii)] (ii) at least 75 percent of the patients who can reasonably be expected to receive the institutional health service will be individuals enrolled with such organization or organizations in the combination;

(B) a health care facility if (i) the facility primarily provides or will provide inpatient health services, (ii) the facility is or will be controlled, directly or indirectly, by a health maintenance organization or a combination of health maintenance organizations [which has, in the service area of the organization or service areas of the organizations in the combination, an en-

rollment of at least 50,000 individuals], (iii) the facility is or will be geographically located so that the service will be reasonably accessible to [such enrolled individuals] *individuals enrolled in such organization or organizations*, and (iv) at least 75 percent of the patients who can reasonably be expected to receive the institutional health service will be individuals enrolled with such organization or organizations in the combination; or

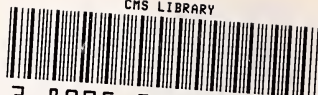
(C) a health facility (or portion thereof) if (i) the facility is or will be leased by a health maintenance organization or combination of health maintenance organizations [which has, in the service area of the organization or the service areas of the organizations in the combination, an enrollment of at least 50,000 individuals] and on the date the application is submitted under paragraph (2) at least fifteen years remain in the term of the lease (ii) the facility is or will be geographically located so that the service will be reasonably accessible to [such enrolled individuals] and (iii) at least 75 percent of the patients who can reasonably be expected to receive the institutional health service will be individuals enrolled with such organization

if, with respect to such offering, aquisition, or obligation, the State Agency has, upon application under paragraph (2), granted an exemption from such requirement to the organization, combination of organizations, or facility.

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